Physician Reimbursement Systems

2019 Urology Advanced Coding and Reimbursement Seminar

Las Vegas

Friday, Nov 30, 2018

12301 Grant St. #230
Thornton, CO 80241
800.972.9298
Fax 303.534.0577
www.prsnetwork.com
Welcome

M. Ray Painter, MD, FACS
Our Speakers

John Lin, MD
Bob Dowling, MD
Larry A. Kemp, FACHE
Mark N. Painter, CMPA, MBS
Housekeeping Items

- **Catchbox** – Throwable Microphone
- **Special Thank You** to the Exhibitors, Exhibitor Introductions
- **Special Session**
  4:30 PM   Compensation Trends: Physicians/APPs and Practice Leaders

- **Happy Hour**
  5:30 – 6:30 PM (after the special session)
  – Speakers and PRS Staff will be available in Suite #2261A
  – Please join us for a drink
  – Get more of your questions answered
  – Meet other attendees
Housekeeping Items Continued

• **Lunch Today and Breakfast Tomorrow** (Starting at 7 AM) at Le Buffet
  • Located Between Bally’s and Paris
  • Please Wear Name Badge / Scan for Entry
  • VIP Diamond Entrance

• **Seminar Follow Up Site**: You will be emailed an invitation to join the *UACRS Group* on the [http://members.prsnetwork.com](http://members.prsnetwork.com) site

• **Slides, scenarios, questions, answers** and other pertinent seminar information will be uploaded to that site

• **Continue the discussion**, get your questions answered, share your experiences, connect with other attendees, be a part of the UACRS community, tap in to the collective genius
Housekeeping Items Continued

• **Attending Both Days:** please wear your name badge both days

• **As you leave the Seminar**
  • On the back of your name badge is a form
    1. please check the items you are interested in
    2. drop it in the bin at the registration table
    3. we will email you the information

• Please recycle the badges and lanyards, if you do not want to keep them

• **AAPC CEUs:** stop by the registration desk during the afternoon break or after the seminar **each** day to get your badge scanned

• **Submitted Questions/Topics** not covered at the seminar will be addressed will be addressed in the **UACRS Group**
Today’s Agenda

AM

8:00 AM – Welcome

8:15 AM – Coding Rules and Regulations
  - Bundling, Modifiers and Global

*9:45 AM – Break

10 AM – Operative Communication From Clinical to Billing

10:30 AM – Interactive Q and A and Scenarios

*12:00 NOON – Lunch at Le Buffet
  (located between Bally’s and Paris)
Today’s Agenda

1:00 PM - MACRA
   - Year 3 MIPS and APM Option
2:00 PM - Medicare Updates 2018
*3:00 PM - Break
3:15 PM - Positioning the Practice for Profitability
   - Aligning Analytics, Opportunities, Tactical Leadership

Special Session

4:30 PM Compensation Trends: Physicians/APPs and Practice Leaders

5:30 PM Happy Hour
Problem

“You don't know what you don't know”
Why?

"You need to know what you need to know"
What?

Learn what you need to know!
“Be all you can be”
How?

• Question
• Learn
• Apply
Self improvement

Question your knowledge

Embrace Continued learning

Seminars

Scenarios

Podcast

Utilize Technology

Expertise
Question
Learn
Apply
Acknowledgements

- CPT® codes and descriptions only Copyright American Medical Association 20179

- Final Rule: 42 CFR Parts 405, 410, 411, 414, 415, 425 and 495 [CMS-1693-F, CMS-1693-IFC, CMS-5522-F3, and CMS-1701-F] RIN 0938-AT31, 0938-AT13, & 0938-AT45 Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program--Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions from the Medicare Shared Savings Program--Accountable Care Organizations--Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act
Coding Rules and Regulations - Bundling, Modifiers and Globals
Global Payments

“Payment for primary procedure includes payment for pre-op services, all components of the surgery, and the postoperative care”
## MEDICARE GLOBAL 0, 10, & 90 DAYS

Private may be different

<table>
<thead>
<tr>
<th>Pre-OP</th>
<th>Day of Procedure</th>
<th>Post-OP</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1 Day</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>1 Day</td>
<td>10 Days</td>
</tr>
<tr>
<td>90</td>
<td>1 Day</td>
<td>90 Days</td>
</tr>
</tbody>
</table>
Private Payer

*Not Required to follow Medicare or CPT Rules or Guidelines*

- Rules determined by contract
- May recognize Modifier -57 over -25 with 0 and 10 Global Procedures
- May require a separate diagnosis with -25
CPT Surgical Package Definition

The services provided by the physician to any patient by their very nature are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services “included” in a given CPT surgical code, the following services are always included in addition to the operation per se:

• Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
• Subsequent to the decision for surgery, one related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of procedure (including history and physical)
• Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
• Writing orders
• Evaluating the patient in the post anesthesia recovery area
• Typical postoperative follow-up care
Medicare Definition Chapter 12 40.1.A.
Components of a Global Surgical Package B3-15011, B3-4820-4831

The Medicare approved amount for these procedures includes payment for the following services related to the surgery when furnished by the physician who performs the surgery. The services included in the global surgical package may be furnished in any setting, e.g., in hospitals, ASCs, physicians’ offices. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon. However, critical care services (99291 and 99292) are payable separately in some situations.
Medicare Definition Chapter 12 40.1.A.
Components of a Global Surgical Package B3-15011, B3-4820-4831

• Preoperative Visits - Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
• Intra-operative Services - Intra-operative services that are normally a usual and necessary part of a surgical procedure;
• Complications Following Surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;
• Postoperative Visits - Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
Medicare Definition Chapter 12 40.1.A.
Components of a Global Surgical Package B3-15011, B3-4820-4831

- Postsurgical Pain Management - By the surgeon;
- Supplies - Except for those identified as exclusions; and
- Miscellaneous Services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.
Medicare Chapter 12 40.1.B. Services Not Included in the Global Surgical Package

A/B MACs (B) do not include the services listed below in the payment amount for a procedure with the appropriate indicator in Field 16 of the MFSDB. These services may be paid for separately.

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. Please note that this policy only applies to major surgical procedures. The initial evaluation is always included in the allowance for a minor surgical procedure;
- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record;
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery;
Medicare Chapter 12 40.1.B. Services Not Included in the Global Surgical Package

• Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;
• Diagnostic tests and procedures, including diagnostic radiological procedures;
• Clearly distinct surgical procedures during the postoperative period which are not re-operations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples of this are procedures to diagnose and treat epilepsy (codes 61533, 61534-61536, 61539, 61541, and 61543) which may be performed in succession within 90 days of each other;
Medicare Chapter 12 40.1.B. Services Not Included in the Global Surgical Package

• Treatment for postoperative complications which requires a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient’s room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient’s condition was so critical there would be insufficient time for transportation to an OR);
• If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately;
• For certain services performed in a physician’s office, separate payment can no longer be made for a surgical tray (code A4550). This code is now a Status B and is no longer a separately payable service on or after January 1, 2002.
Medicare Chapter 12 40.1.C. Minor Surgeries and Endoscopies

Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. For example, a visit on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Billing for a visit would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status.
A postoperative period of 10 days applies to some minor surgeries. The postoperative period for these procedures is indicated in Field 16 of the MFSDB. If the Field 16 entry is 010, A/B MACs (B) do not allow separate payment for postoperative visits or services within 10 days of the surgery that are related to recovery from the procedure. If a diagnostic biopsy with a 10-day global period precedes a major surgery on the same day or in the 10-day period, the major surgery is payable separately. Services by other physicians are not included in the global fee for a minor procedures except as otherwise excluded. If the Field 16 entry is 000, postoperative visits beyond the day of the procedure are not included in the payment amount for the surgery. Separate payment is made in this instance.
Same Day Services
E/M rules

• Subsequent to the decision for surgery, one related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of procedure (including history and physical) (CPT)

• Preoperative Visits - Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures; (MC)

• Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. (MC)
Modifier -25

• “Significant, separately identifiable E/M service by the same physician on the day of the procedure.”
  1. “Significant”
  2. “Separately Identifiable”

• Different diagnoses not required for reporting of the E/M services on the same date

• *Same physician - same specialty and billing #
What is a Minor Surgery?

Any procedure with 000 or 010 global

Examples:

• 52234  TURBT
• 52353  Stone
• 54161  Circumcision
Modifier -57

**Decision for Surgery:** Medicare

- Use only in conjunction with 90 day global procedures
- Use only if patient is scheduled for surgery the same day or the next calendar day
E/M Out of Office
Rounds and Personnel

• NP/PA reporting in the hospital
  – No incident to billing
  – Shared/Split billing
  – Billing under the NPP NPI

• Multiple providers in the same practice
  – Rules
  – Reporting methods
<table>
<thead>
<tr>
<th>Cross Walk</th>
<th>Initial Visit - Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consults</strong></td>
<td></td>
</tr>
<tr>
<td>Level 5</td>
<td>Level 3</td>
</tr>
<tr>
<td>Level 4</td>
<td>Level 2</td>
</tr>
<tr>
<td>Level 3 (H &amp; P = 1)</td>
<td>Level 1 (MDM-less)</td>
</tr>
<tr>
<td>Level 2</td>
<td>Level -99232 (3)</td>
</tr>
<tr>
<td>Level 1</td>
<td>Level -99231 (2)</td>
</tr>
</tbody>
</table>
### Observation or Hospital Inpatient Care Services

<table>
<thead>
<tr>
<th>Observation Care</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Hospital Care</td>
<td>99218</td>
<td>99219</td>
<td>99220</td>
</tr>
<tr>
<td>Admission &amp; Discharge</td>
<td>99221</td>
<td>99222</td>
<td>99223</td>
</tr>
<tr>
<td></td>
<td>99234</td>
<td>99235</td>
<td>99236</td>
</tr>
</tbody>
</table>

**KEY COMPONENTS**

Must satisfy all three key components.

<table>
<thead>
<tr>
<th>History</th>
<th>Content of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Present Illness</td>
<td>4+ *</td>
</tr>
<tr>
<td>Review of Systems</td>
<td>2 - 9</td>
</tr>
<tr>
<td>PFSH - Family and Social</td>
<td>1 - 2</td>
</tr>
</tbody>
</table>

* An extended can also be reached by documenting the status of at least 3 chronic or inactive conditions.

**Physical (1995)**

- **Affected Organ System**
  - Extended 4+
  - 8 Systems / 1 Element

- **Related Organ System**
  - Extended 4+
  - 8 Systems / 1 Element

**Physical (1997)**

- **Single Organ System**
  - 12+
  - shaded / all unshaded / 1

- **Multisystem - General**
  - 12+
  - 9+/ x 2 ea

**Medical Decision Making**

- **Number of Diagnoses**
  - Minimum
  - Multiple
  - Extensive

- **Amount of Data**
  - Limited
  - Moderate
  - Extensive

- **Amount of Risk**
  - Minimum
  - Moderate
  - High

**CONTRIBUTORY COMPONENTS**

**TIME**

Becomes a key component and overrides other components if over 50% of service is counseling or coordinating.

- Only applies to codes 99221, 99222, and 99223
- 30
- 50
- 70

**PROBLEM**

Problem must justify treatment.

- **Risk of Morbidity**
  - Low
  - Moderate
  - High

- **Risk of Mortality**
  - Low
  - Moderate
  - Mod-High

‡ For Medicare - Admitting physician use A1 modifier
# Subsequent Hospital Care

<table>
<thead>
<tr>
<th>Subsequent Hospital Care</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99231</td>
<td>99232</td>
<td>99233</td>
</tr>
<tr>
<td>Subsequent Observation Care</td>
<td>99224</td>
<td>99225</td>
<td>99226</td>
</tr>
</tbody>
</table>

## Key Components

Must satisfy two of the three key components.

### History

<table>
<thead>
<tr>
<th>History</th>
<th>Content of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Present Illness</td>
<td>1 - 3</td>
</tr>
<tr>
<td>Review of Systems</td>
<td>1 - 3</td>
</tr>
<tr>
<td>PFSH - Family and Social</td>
<td>Pertinent</td>
</tr>
<tr>
<td><em>An extended care can also be reached by documenting the status of at least 3 chronic or inactive conditions.</em></td>
<td></td>
</tr>
</tbody>
</table>

### Physical (1995)

| Affected Organ System          | Limited 1 - 3      |
| Related Organ System           | Limited 1 - 3      |
| **Extended 4+**                |                    |

### Physical (1997)

| Single Organ System            | 1+                  |
| Multisystem - General          | 1+                  |
| **12+**                        |                    |

### Medical Decision Making

<table>
<thead>
<tr>
<th>Minimum</th>
<th>Multiple</th>
<th>Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>None - Min</td>
<td>Moderate</td>
<td>Extensive</td>
</tr>
<tr>
<td>Minimum</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

## Contributory Components

### Time

Time becomes a key component and overrides other components if over 50% of service is counseling or coordinating.

| Subsequent Hospital Care | 15 | 25 | 35 |

### Problem

Problem must justify treatment.

<table>
<thead>
<tr>
<th>Risk of Morbidity</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of Mortality</td>
<td>Mod-High</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>
Potential Level - Hospital Admit

Assumes that you have a complete Hx and comprehensive PE documented. The following is a guide for each level.

Level 3

• Patient w/acute sepsis in need of diagnostic tests to decide treatment.

• Patient w/multiple lab tests, CT scan or x-ray requiring major surgery with identified risk factors

• Patient w/multiple active problems (stone and BPH and ED) requiring major surgery with identified risk factors
Potential Level - Hospital Admit

Assumes that you have a complete Hx and comprehensive PE documented. The following is a guide for each level

**Level 2**

- New problem to you with Rx drug ordered
- Established problem multiple lab and X-Ray test and a diagnostic endoscopy
- New problem requiring lithotripsy either through scope or ESWL
Potential Level - Hospital Admit

Level 1
— 3rd level new patient Hx and detailed PE

• Medical decision-making
  • Minimum
  • Or, any level of MDM, if the above H&P is documented, but a complete H&P is not documented
  • Or, Charge by Time
## Emergency Room

<table>
<thead>
<tr>
<th></th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td>99281</td>
<td>99282</td>
<td>99283</td>
<td>99284</td>
<td>99285</td>
</tr>
</tbody>
</table>

### Key Components
Must satisfy all three key components.

#### History

<table>
<thead>
<tr>
<th>History of Present Illness</th>
<th>Content of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 3</td>
<td>1 - 3</td>
</tr>
<tr>
<td>4+ *</td>
<td>4+ *</td>
</tr>
<tr>
<td>Pertinent</td>
<td>2 - 9</td>
</tr>
<tr>
<td>2 - 3</td>
<td>10+</td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

*An extended can also be reached by documenting the status of at least 3 chronic or inactive conditions.*

#### Physical (1995)

| Affected Organ System     | Limited 1/3 | Limited 1/3 | Limited 1/3 | Extended 4+ | 8 Systems |
| Related Organ System      | Limited 1/3 | Limited 1/3 | Limited 1/3 | Extended 4+ | 1 + Element |

#### Physical (1997)

| Single Organ System       | 1+          | 6+          | 6+          | 12+         | shaded / all shaded / 1 |
| Multisystem - General     | 1+          | 6+          | 6+          | 12+         | 9+/ x 2 ea |

#### Medical Decision Making
Must satisfy two of the three elements.

| Number of Diagnoses       | Minimum    | Limited   | Multiple   | Multiple   | Extensive |
| Amount of Data            | Minimum    | Limited   | Moderate   | Moderate   | Extensive |
| Amount of Risk            | Minimum    | Low       | Moderate   | Moderate   | High      |

### Contributory Components

#### Problem
Problem must justify treatment.

| Risk of Morbidity         | Low-Mod    | Moderate  | High      | High      |
| Risk of Mortality         | Zero-Mod   | Moderate  | Mod-High  | Mod-High  |
Discharge

• 99217 Observation care discharge day management

• 99238 Hospital discharge day management; 30 minutes or less

• 99239 Hospital discharge day management; more than 30 minutes
Admit and Discharge

- Requires 8 hours in obs or inpatient setting on same date

- Transfer within facility does not qualify if provided on same DOS

- Date Driven pay attention
Global Payments

“Payment for primary procedure includes payment for pre-op services, *all components of the surgery*, and the postoperative care”
Intra-Service (CPT)

In defining the specific services “included” in a given CPT surgical code, the following services are always included in addition to the operation per se:

• Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia

• Immediate postoperative care, including dictating operative notes, talking with the family and other physicians

• Writing orders

• Evaluating the patient in the post anesthesia recovery area
Intra-Service Medicare

• Intra-operative Services - Intra-operative services that are normally a usual and necessary part of a surgical procedure;

• NCCI
Bundled Codes

• Procedures that are an *integral part* or *component* of another procedure
• Apply to multiple procedures *at the same encounter only*
• Payment edits
  - Medicare - correct coding edits (CCI)
  - For private carriers - “Black box”
Unbundling Modifiers

- 59
- RT (Right)
- LT (Left)
Modifier -59
CPT – Private Payers
• Different patient encounter
• Different site or organ system
• Separate incision or excision
• Different procedure or surgery
• Separate lesion or injury
-X[E,P,S or U] Modifiers

Medicare and Some Private Payers

- XE – Separate encounter
- XS – Separate structure/organ
- XP – Separate practitioner
- XU – Unusual non-overlapping services
Modifier -51
Multiple Procedures

• Append to lesser procedures
• Use for private payers only
• **WILL NOT “UNBUNDLE”**
Assistant at Surgery

• -80 Assistant at surgery
• -81 Minimal assistant at surgery
• -82 Resident not available/teaching hospital
• -AS Assistant at surgery NPP
Modifier -62
Co-Surgeons

• Use **only** if 2 surgeons; each perform distinct parts of a procedure or procedures described by 1 CPT code

• Both surgeons must dictate an operative note for the procedure or part they performed

• Medicare requires different specialties for each provider
Bilateral Procedures - Medicare

- If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), physicians must report the procedure with modifier “-50.”

- If a procedure is identified by the terminology as bilateral (or unilateral or bilateral), physicians do not report the procedure with modifier “-50.”
Modifier -22

Increased Procedural Service:

- Use only when there is increased work, time and complexity of procedure by physician or other qualified provider
- Submit electronically
Modifier -53
Discontinued Procedure

• Procedure terminated due to circumstances that threaten the well-being of the patient.
• Terminated after a procedure started
• Can be used with surgery of DX procedure
Modifier -52
Reduced Services

• Service or procedure is partially reduced
• Procedure was started, but not completed
• Means of reporting without disturbing basic CPT descriptor
• Medicare pays 50% of listed payment
Modifiers - Split Surgical Care

-54 Surgical Care Only
-55 Postoperative Management Only
-56 Preoperative Management Only

• Requires coordination between facilities
• Medicare pays each doctor according to care provided
• Cannot exceed total allowed amount for one physician
Global Payments

“Payment for primary procedure includes payment for pre-op services, all components of the surgery, and the postoperative care”
Unrelated Services
Modifier -79

- Unrelated procedure or service by the same physician during the postoperative period
- Unrelated to primary procedure
- **Use new diagnosis**
Modifier -24

“Unrelated E/M service by the same physician during a postoperative period”

- E/M service only
- Unrelated to the original procedure
- A separate diagnosis is necessary
Complications
Modifier -78

- Related procedure / complication
- Treated in a formal operating room or procedure room
- Pays work value only
Staged
Modifier -58

Staged or related procedure or service

• (a) planned or anticipated (staged)
• (b) more extensive than the original procedure
• (c) for therapy following a surgical procedure
### TABLE 2: Application of Payment Modifiers to Utilization Files

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Volume Adjustment</th>
<th>Time Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>80,81,82</td>
<td>Assistant at Surgery</td>
<td>16%</td>
<td>Intraoperative portion</td>
</tr>
<tr>
<td>AS</td>
<td>Assistant at Surgery – Physician Assistant</td>
<td>14% (85% * 16%)</td>
<td>Intraoperative portion</td>
</tr>
<tr>
<td>50 or LT and RT</td>
<td>Bilateral Surgery</td>
<td>150%</td>
<td>150% of work time</td>
</tr>
<tr>
<td>51</td>
<td>Multiple Procedure</td>
<td>50%</td>
<td>Intraoperative portion</td>
</tr>
<tr>
<td>52</td>
<td>Reduced Services</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>53</td>
<td>Discontinued Procedure</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>54</td>
<td>Intraoperative Care only</td>
<td>Preoperative + Intraoperative Percentages on the payment files used by Medicare contractors to process Medicare claims</td>
<td>Preoperative + Intraoperative portion</td>
</tr>
<tr>
<td>55</td>
<td>Postoperative Care only</td>
<td>Postoperative Percentage on the payment files used by Medicare contractors to process Medicare claims</td>
<td>Postoperative portion</td>
</tr>
<tr>
<td>62</td>
<td>Co-surgeons</td>
<td>62.5%</td>
<td>50%</td>
</tr>
<tr>
<td>66</td>
<td>Team Surgeons</td>
<td>33%</td>
<td>33%</td>
</tr>
</tbody>
</table>
Questions
Break

Thank you to our exhibitors
We help physicians and staff maximize reimbursement and compensation.

Subscribe now to get first access to free coding, billing and reimbursement articles, tip, tools, webinars and seminars.

Subscribe Now for Free
Contact Info:

• Email: jclin@SunriseUrology.com

• Facebook
• Instagram
• Twitter
• Snapchat

• *The Thriving Urology Practice* – Facebook Group
Operative Communication from Clinical to Billing

Why and How
“The OR” is an expensive hobby

Efficiency = key!
Documentation

- **Proof of Service** - Details of procedure and/or services

- **Medical Necessity** - Reason for procedure(s) and/or services

- **Separate** - Documentation for each service to be charged
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network
Official Information Health Care Professionals Can Trust

Evaluation and Management Services

https://go.cms.gov/1S4PeEg
MEDICAL RECORD DOCUMENTATION

Learn about the general principles of evaluation and management (E/M) documentation, common sets of codes used to bill for E/M services, and E/M services providers.

GENERAL PRINCIPLES OF E/M DOCUMENTATION

If it is not documented, it has not been done.

Clear and concise medical record documentation is critical to providing patients with quality care and is required for you to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient’s health history. Medical record documentation helps physicians and other health care professionals evaluate and plan the patient’s immediate treatment and monitor the patient’s health care over time.
Importance of Documentation

- Proof of service
- Medical necessity
- Value based payments
- ICD-10
- Patient access and review
- Payer scrutiny
- Medical-legal
Global Payments

”Payment for primary procedure includes payment for *pre-op services, all components of the surgery*, and the *postoperative care”

Bundling rules – for payers to prevent payments for certain components of a surgery
Sidebar on “globals”

- Circumcision
- ESWL F/U
- TURP F/U
- UroLift F/U
- Vasectomy
Explain Nuances

• Multiple procedures (-51)
• Components of main procedure
• Separate structure/lesion (-59/XS)
• Separate encounter (-59/XE)
• Separate incision (-59)
• Different procedure / Unusual non-overlapping services (-59/XU)
• Bilateral (-50), LT/RT
Explain Nuances

- Size of lesion (e.g., bladder Ca)
- “Extended” / “Complex” (-22)
- Unexpected return to OR (-78)
- “Staged” (-58)
- “Due to regrowth” (e.g., TURP)
- Number of implants above MUE
Op Note Check List

• Patient info / Demographics, etc.
• Surgeon / Assistant Surgeon / Co-Surgeon
• Place of service
• Accurate diagnosis(es) / Medical necessity
• "Global" issues / Circumstances
• Procedure details
Communication

• What is the optimal method to communicate physician’s hospital/ASC charges to billing staff?
  — Face sheet + chicken scratch?
  — Notecards / paper + chicken scratch?
  — Coding staff reads operative report and determining the ICD-10s and CPTs provided?
  — Electronic?
    • Doc connects to ofc? Staff queries hospital(s’) systems?
  — Voice?
  — Other?
Don’t Reinvent the Wheel

each time a surgery is performed
Communication - Best practices

• Consider developing a short list of procedures + ICD-10 codes for each physician
• Physician documents all services provided with primary diagnosis + nuances
• Use *electronic app or paper*
• Communicate on the day of surgery
Develop “short list”

• Identify the most frequent procedures performed by each provider
  — In the hospital: scheduled & In-pt/ER cases
  — In the ASC: scheduled cases
  — In office: scheduled procedures

• Urologist, coders, and billers work together to determine appropriate codes and billable code sets: ICD-10s + CPTs
Communication

• Determine modality and process
  — Paper
    • Delivery plan: hand-carry, fax, courier, mail, pony, etc.
  — Electronic
    • Secure email, website, app, EHR, photo, voice.
<table>
<thead>
<tr>
<th>DATE &amp; TIME</th>
<th>IMMEDIATE POST-OPERATIVE SURGICAL PROGRESS NOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-Op Dx: □ Right □ Left □ Ureteral Stone □ Renal Stone</td>
</tr>
<tr>
<td></td>
<td>□ Flank Pain □ Hydronephrosis □ ____________________________</td>
</tr>
<tr>
<td></td>
<td>Post-Op Dx: □ Same □ ____________________________</td>
</tr>
<tr>
<td></td>
<td>Procedure(s): cystoscopy, □ right □ left</td>
</tr>
<tr>
<td></td>
<td>□ DIAGNOSTIC ureteroscopy (□ complex, □ staged)</td>
</tr>
<tr>
<td></td>
<td>□ ureteroscopy with laser LITHOTRIPSY (□ Sep/Distinct, □ complex, □ staged)</td>
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<tr>
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<td>□ ureteroscopy with laser LITHOTRIPSY (□ Sep/Distinct, □ complex, □ staged)</td>
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<tr>
<td></td>
<td>□ ureteroscopy with stone MANIPULATION (□ Sep/Distinct, □ complex, □ staged)</td>
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<tr>
<td></td>
<td>□ ureteroscopy with stone MANIPULATION (□ Sep/Distinct, □ complex, □ staged)</td>
</tr>
<tr>
<td></td>
<td>□ ureteral stent placement</td>
</tr>
<tr>
<td></td>
<td>□ retrograde pyelography</td>
</tr>
<tr>
<td></td>
<td>□ intraoperative fluoroscopy.</td>
</tr>
<tr>
<td></td>
<td>Surgeon: John C. Lin, M.D.</td>
</tr>
</tbody>
</table>
Immediate Post-ESWL Progress Note

Pre-Op Dx: □ Left □ Right □ Renal Stone □ Ureteral Stone

Post-Op Dx: □ Same □

Procedure(s): □ Left □ Right Extracorporeal Shock Wave Lithotripsy □ Staged

Surgeon: John C. Lin, M.D.

Anesthesiologist:

Type of Anesthesia: □ General □ Spinal □

EBL: □ None □ Minimal □

Drains: □ None □ Pre-existing ureteral stent
□ _____ x _____ cm Ureteral Stent
□ _____ Fr Foley

Specimen(s): □ None

Complications: □ None □

Operative Findings: □ 2,500 □ ______ shocks at 60 - _____ PPM

Power: 1 -

Power Source: □ EMSE □ Spark gap (EH)

Lithotriptor: □ Dornier Compact Delta II
□

Approach: □ Posterior □ Anterior

□ Excellent □ Partial fragmentation noted

□ Additional treatment may be needed to achieve full clearance

Follow Up: □ KUB & Ofc Visit in ______ Weeks / Months □ Diet #

Patient ID Label Here
How I do it: ER / IP to OR

• Dictated H&P: Gives clue to staff re: dx & plan
• Immediate Post Op Note (IPON): More clues re: diagnosis + procedures
• Fax both “Face Sheet” + IPON to office from PACU: “secure”, compliant, no paper to carry.
• If it’s an existing office pt seen in ER:
  – Document in office EHR: (VPN) PSH + Dx + eRx + post op f/u plan.
• Go home.
Cystoscopic insertion of ureteral stent (52332) [11/15/2018]: Right.

Ureteral stone (N20.1) (Impression: Right 9mm 1100 Hounsfield Units UPJ stone on CT 11/14/2018):

- Restarted Cipro 500MG, 1 (one) Tablet two times daily, #2, 1 day starting 11/15/2018, No Refill.
- Restarted Tylenol with Codeine #3 300-30MG, 1 (one) Tablet Tablet every four hours, as needed
- Follow Up in 1-2 weeks
How I do it: **Office to OR**

*Existing patient in practice*

- In-office H&P in EHR: ICD-10, CPTs.
- Scheduler: “Short list” on “booking sheet”.
  - Copy-and-paste to e-booking, if needed.
- Immediate Post Op Note: Convey *nuances*
- **Fax** IPON to office from PACU: “secure”, compliant, no paper to carry.
- **Document in office EHR:** (VPN) PSH + Dx + eRx + post op f/u plan.
- Go home.
### MGMC / CRMC PRE-OPERATIVE ORDERS

1. Fax Orders to Pre-OP Scheduler: 480 728-9667
2. Fax Orders to Pre-Op Dept: 480 728-9669
3. Call Scheduler: 480 728-3873

<table>
<thead>
<tr>
<th>Patient Name: «PName»</th>
<th>Date of Birth: «PDOB»</th>
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</thead>
<tbody>
<tr>
<td>SSN: «PSSN»</td>
<td>Gender: «PSex»</td>
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| **Address:**
  «PStreet1»
  «PStreet2»
  «PCity», «PState»
  «PZipCode»          | **Home Phone:** «PHTele» |
|                       | **Cell Phone:** «PCTele» |
|                       | **Work Phone:** «PWTele» |

#### Diagnoses:
- Bladder Mass (ICD-10: D49.4)

#### Surgical Consent to Read:
- Transurethral Resection of Bladder Tumor, Small (CPT: 52234)
- Transurethral Resection of Bladder Tumor, Medium (CPT: 52235)
- Transurethral Resection of Bladder Tumor, Large (CPT: 52240)
- with Immediate Post Op Intravesical Chemotherapy (CPT: 51720)

<table>
<thead>
<tr>
<th>Surgeon: John C. Lin, M.D.</th>
<th>Surgeon Phone: 480 507-9600</th>
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<tbody>
<tr>
<td>PCP: «PCPName»</td>
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<tr>
<td>Date of Surgery:</td>
<td>Time of Surgery:</td>
</tr>
<tr>
<td>Length of Procedure:</td>
<td>Patient Instructed to Arrive at (time):</td>
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#### INSURANCE INFORMATION

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<thead>
<tr>
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<th>ID/Policy #: «PL1Cert» «PL1CertSuffix»</th>
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<tr>
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<td>Group #: «PL1GroupNo» «PL1GroupName»</td>
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<table>
<thead>
<tr>
<th>Status: Outpatient (OP)</th>
<th>Post Surgical Admit</th>
<th>Possible Post Surgical Admit (PPSA)</th>
<th>AM Admit (AA)</th>
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### OR Schedule in EHR

**Location:** Sunrise Urology, PC

<table>
<thead>
<tr>
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<tr>
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<td>-</td>
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<td>08:30 AM</td>
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• Positioning
Interactive Q and A
Operative Report

Service Date: 02/20/2018

PREOPERATIVE DIAGNOSIS: Urinary retention.
POSTOPERATIVE DIAGNOSIS: Urinary retention.
PROCEDURE: Cystoscopy with placement of suprapubic tube.
DRAINS: A 16-French suprapubic tube.
COMPLICATIONS: None.
INDICATIONS: This is a 76-year-old Caucasian female with urinary retention who presents for placement of suprapubic tube.
DESCRIPTION OF PROCEDURE: Following informed consent, the patient was taken to the operating room. IV sedation was given. She is placed in lithotomy. The external genitalia and lower abdomen were prepped and draped in normal sterile fashion. A Lowsley retractor was placed transurethrally into the bladder. The bladder dome was tented up the skin and an incision is made after injection of 1 % Xylocaine and the Lowsley is poked through the skin. We grabbed the distal end of the catheter, pulled it out the urethra and then followed it back in the bladder with the scope and then inflated the balloon, secured the catheter in place with a 3-0 silk suture. The patient was awakened from anesthesia and taken to recovery room in stable condition.
Service Date: 03/13/2018

PREOPERATIVE DIAGNOSIS: Neurogenic bladder.

POSTOPERATIVE DIAGNOSIS: Neurogenic bladder.

PROCEDURE PERFORMED: Cystoscopy and suprapubic cystostomy tube placement.

DRAINS: Include a 16 French suprapubic catheter to gravity.

INDICATIONS FOR THE PROCEDURE:

- The patient is a patient with a history of a neurogenic bladder secondary to a spinal cord stroke. She has neurogenic bowel as well. She has been unable to learn self-catheterization. After discussion of treatment options, she presents today for suprapubic catheter placement.

DESCRIPTION OF THE PROCEDURE: The patient was identified in the holding area. Informed consent was obtained. She was taken back to the operating room. A general anesthetic was induced in the supine position. She was transferred to the lithotomy position. The vagina was prepared in a sterile fashion with Hibiclens. Time-out was performed. A 70 degree cystoscope was introduced into the bladder. The bladder was filled with 300 ml of sterile water. Once the bladder was distended, 2% lidocaine with epinephrine was injected into the skin just above the pubic bone. This was introduced into the bladder, and the needle was seen directly through the cystoscope. Ten milliliters of 2% lidocaine was injected along the proposed suprapubic catheter tract, and then a small incision was made in the skin. A Bard trocar W<IS introduced into the bladder and again directly visualized through the scope. The obturator was removed, and a 16 French Foley catheter was placed; 5 ml was placed in the balloon. The peel-away sheath was removed. The catheter was secured with a suture, and a dry dressing was placed. The patient was awakened from anesthesia and transported to the recovery room in stable condition.
**Date of Service**  
5/10/2018

**Indication for Surgery**  
Neurogenic bladder, recurrent urinary infection. The patient has history of urinary tract infection and rhabdomyolysis. He is currently being treated for UTI. He has had a Foley catheter in place for urinary retention and he has history of urinary incontinence. He pulled out the catheter on multiple occasions. He presents today for suprapubic cystostomy.

**Preoperative Diagnosis**  
Neurogenic bladder, recurrent urinary infection

**Postoperative Diagnosis**  
Same

**Operation**  
Cystoscopy with suprapubic cystostomy

**Technique**  
Patient was identified in the holding area as a minister IV antibiotics. Informed consent was obtained. He was taken back to the operating room. IV general anesthesia was induced the supine position. The lower abdomen was shaved and the scrotum and penis were prepared in sterile fashion. Surgical timeout was performed. One percent lidocaine with epinephrine was injected through the spinal needle just to the right of his midline abdominal scar and above the pubic bone. 10 ml of local anesthetic was placed. A 70° cystoscope with 22 French sheath was introduced into the bladder. The bladder was distended with 300 mL of normal saline. No pathology was noted on cystoscopy. The spinal needle was then advanced into the bladder under direct vision. A small incision was made and hemostats were used to dissect down to the detrusor under direct vision. I then placed a Bard suprapubic trocar into the bladder. The obturator was removed and a 16 French catheter was introduced through the sheath. The sheath was peeled away and the catheter was secured to the abdomen with a silk suture. The cystoscope was removed and the suprapubic catheter was placed to gravity drainage. The patient was awakened from anesthesia and transported to the recovery room in stable condition.
Part 1

Question about instilling chemo in the hospital recovery room after bladder tumor resection in the OR.

52234-52240: Cystourethroscopy with resection of bladder tumor

51720: Bladder instillation of anticarcinogenic agent

In order to unbundle these two CPT codes you’d have to append a modifier 59 (distinct procedural service) to CPT 51720.
Part 2

Our scenario: The patient is brought to the OR for transurethral bladder tumor resection and chemo instillation. The OR does not allow for us to order chemo until the procedure is completed due to the possibility of complications that may change the need for the drug, in which it would then be wasted. Due to this, once the resection is complete the physician orders the drug and then have to wait for the drug to be mixed and brought to the OR for instillation. This process takes a minimum of 30 minutes and as a result, the patient is transferred to the recovery room to wait for the chemo to arrive where it will then be instilled there in recovery.
Part 3

Our question: Theoretically, keeping in mind that medical necessity should be the overarching criterion of every service provided, you can append modifier 59 to 51720 due to the “separate session” in this scenario. However, do facility rules and processes which are forcing this “separate session” support the medical necessity required to report 51720 separately as a distinct procedural service? Or would this service be reported as a whole using just 52234-52240 as the intent would be to instill in the OR if the drug arrived in a reasonable time frame?
Unlisted Codes

• How to get pay for unlisted codes? How long takes to have a code for all the procedures we are using unlisted codes?
Interoperative Consults

• Are intraoperative consultations billable and if so, what documentation is needed?

• For example, our doctors will get called in during a Hysterectomy because of a bladder puncture. Our docs dictate an OP note for the bladder repair but there is no separate consult note.
Supplies and Drugs

- Are DMERC supplies billable? Example, leg bag, catheters, bedside bag, etc.
- Supplies (e.g., catheters, stoma supplies, etc.) used during direct patient care or given out to patients in the clinic setting – are these billable?
- How should we handle generic testosterone pallets? Should we file to insurance, what insurance’s pay for these?
Supplies and Drugs

- We are currently giving Lupron injections for Prostate Cancer - however we are not getting reimbursed for the cost of the injection at the cost we pay for it. We pay $1100.00 for one 6 month injection and we are only getting reimbursed approx. $483.00. We are charging an E/M for the visit with a modifier of 25, J9217 x the total number of units, 96402 for the injection. Any suggestions to increase the reimbursement on this or should we just not do them anymore and send them to the hospital to get the injection?
Supplies and Drugs

• A physician has a ninety year old patient being treated for prostate cancer with Lupron injections.
  – Patient is now under hospice care for another diagnosis. Is doctor able to continue Lupron therapy for this patient? If so, how are these charges billed?

• Cancer diagnosis assigned to a patient who has undergone surgical removal of the cancer with no symptoms of the disease present:
  – Example removal of the prostate two years prior to present encounter, not actively being treated for prostate cancer, doctor administers a Lupron injection for maintenance therapy—how do I code this?
How do you code for new procedures

• Does the physician report C9738 on their billing for blue light
cystoscopy, or is that just the facility?

• UroLift

• Rezum
  – Rezum 53852: Many of the patients are coming back to the office for PVR or catheter exchange. Can I use a 58 modifier for those CPT codes if the Dr. states in the dictation that the patient, "may need re-catheterizing or other treatments if he has significant urinary retention or gross hematuria?"

• SpaceOAR
Other Procedures and situations

- How do you code/bill for urgent pc stimulator?
  - Can you code an Office visit? How?
- If we do a routine cath change in the office and have to irrigate to check placement can we also charge for irrigation?
- What procedure codes and modifier (if any) should I be billing for a prostate biopsy being done as outpatient in the OR?
- I am finding that not all insurance companies will pay for both 51741 and 51798 when they are done in the office on the same day. Am I billing incorrectly?
Other Procedures and situations

• How do you code a laparoscopic mace procedure?
• What is the proper code for a “robotic salvage prostatectomy?”
• What is the current recommendation for coding a simple laparoscopic prostatectomy? It used to always be 55866-52 but I have read recently that this has changed.
• We are paid on an RVU scale and practice at a rural hospital where we routinely assist each other on robotic or oncologic cases. What strategies have worked well to compensate the assisting physician for their time so that they do not get penalized for helping and promoting camaraderie?
Other Procedures and situations

• I code surgeries and what I seem to have difficulty with is the hidden penis or the buried penis how these are different especially now that insurances are looking for prior authorization.

• We also seem to have issues with Robotic-laparoscopic-ureterolysis procedures. I'm curious about how others are getting reimbursed for these procedures. My chair seems to want to know why S2900 doesn't have a compensation value to it.
Other Procedures and situations

• Our clinic is having problems with getting 51726-26 paid by Medicare. Any suggestions on how to get reimbursed is appreciated.

• Are BCG treatments considered staged with a 58 mod (its planned or may be anticipated to start BCG’s after surgery) but also not related to the surgery (not wound recovery, complications) and is treating the underlying condition and could be considered unrelated with a 79 mod?
Other Procedures and situations

• Our clinic is having problems with getting 51726-26 paid by Medicare. Any suggestions on how to get reimbursed is appreciated.

• Are BCG treatments considered staged with a 58 mod (its planned or may be anticipated to start BCG’s after surgery) but also not related to the surgery (not wound recovery, complications) and is treating the underlying condition and could be considered unrelated with a 79 mod?
Other Procedures and situations

• How do you bill for procedures that are bundled such as a cysto done in the office, then the patient has to be admitted or ends up at the hospital for cysto w/clot irrigation... I know they are done at different locations but the 59 modifier doesn’t work because the two codes can never be billed together on the same day and a 59 doesn’t work. I know I could appeal but I’m wondering if anyone knows an easier way since I’m sure this happens often and there must be some way to bill for both or maybe there isn’t.
Other Procedures and situations

• How do you bill for procedures that are bundled such as a cysto done in the office, then the patient has to be admitted or ends up at the hospital for cysto w/clot irrigation... I know they are done at different locations but the 59 modifier doesn’t work because the two codes can never be billed together on the same day and a 59 doesn’t work. I know I could appeal but I’m wondering if anyone knows an easier way since I’m sure this happens often and there must be some way to bill for both or maybe there isn’t.
Other Procedures and situations

• What or can we charge for a Medical Assistant to remove a catheter after a 0 global surgery?
  — Example: Patient has a TURBT on Tues. and comes to the office to have it removed by the Medical Assistant the next day.

• Are Urologist able to legally do self referrals? Medicare does not specifically state the do's of "Self Referrals." I can only find the don'ts. Any advice on this would be appreciated.
Other Procedures and situations

• AUA Coding Today, CPT 96372 states, "Do not report 96372 for injections given without direct physician or other qualified health care professional supervision. To report, use 99211."
  — Is an Certified Medical Assistant consider a qualified health care professional?

• I was wondering if we could go over appropriate documentation for interpretation of Urodynamic studies.
Location billing

• Can you discuss different scenarios of inpatient/outpatient/ER situations? Such as a patient is evaluated in the ER and an ER note dictated, maybe taken to the OR and OP note is outpatient or observation...would you code the E/M portion the same as the surgery? Or bill each at different locations? I’m just curious if there are any generalizations to learn about hospital locations and hospital billing.
Difficult Operative notes

• I have difficulty coding operative reports for DVIU, BNI or bladder neck resection. Can you give me some key points to look out for that would steer me to the correct code. Thank You.
Operative Notes
Lunch

Thank you to our exhibitors
MACRA – Year 3 MIPS and APM Update for Urology

Bob Dowling MD

Dowling Medical Director Services LLC
Disclosures

• Principal Dowling Medical Director Services
  – Chief Medical Officer for large urology groups
  – No current industry relationships

• Contributing Author Urology Times

• Member MACRA Episode-Based Cost Measure Clinical Subcommittee on Urologic Disease Management
Agenda

• Quality Payment Program Review
  – Basics
  – 2019 Updates
  – Take home messages

• Impact in Urology

• What you can do to avoid a penalty and achieve a positive payment adjustment

• Q & A
Medicare Access And CHIP Reauthorization Act 2015

• MACRA is **bipartisan** legislation signed in April 2015 and now being implemented by CMS that replaced SGR\(^1\) methodology with
  1. a baseline physician fee schedule update
  2. payment system based upon **fee for service** with quality measurement
     • MIPS\(^2\): pay for performance, fee schedule adjustment, default pathway
       OR
     • Advanced Alternative Payment Model: pay for **qualified** participation in a system managing populations, bonus payment
  3. Creation of pathway for new aAPMs (PTAC)

SGR = sustainable growth rate
MIPS = Merit Based Incentive Payment System
Legislative Change
February 2018

• H. R. 1892 Balanced Budget Act (BBA) was signed into law February 9, 2018
  — This law makes significant permanent changes to MIPS by amending section 1848 of the Social Security Act (governing physician reimbursement)
MIPS Changes in BBA 2018

Before BBA 2018

• MIPS payment adjustments beginning 1/2019 apply to professional services and other part B items including part B drugs

Under BBA 2018

• MIPS payment adjustments beginning 1/2019 only apply to professional services, defined as deriving from fee schedule (MPFS)

IMPACT: This change means urologists will not be punished or rewarded on buy and bill charges like leuprolide, sipuleucil-T, BCG
MIPS Changes in BBA 2018

Before BBA 2018

2019-2021 Performance Year | 2021-23 Payment Year

- Quality: 30%
- Cost: 25%
- IA: 15%
- ACI: 15%

Under BBA 2018

2019-21 Performance Year | 2021-23 Payment Year

- Quality: 25%
- Cost: COMPLEMENT OF COST 30-50%
- IA: PER HHS DISCRETION 10-30%
- ACI: 15%
MIPS Changes in BBA 2018

Before BBA 2018
• Improvement in cost category performance is rewarded in bonus points for PY 2018-2021.

Under BBA 2018
• Improvement in cost category performance is not rewarded in bonus points for PY 2018-2021.
## MIPS Changes in BBA 2018

### Before BBA 2018
- MIPS composite score threshold
  - 2017 3/100
  - 2018 15/100
  - 2019- actual mean or median

### Under BBA 2018
- MIPS composite score threshold
  - 2017 3/100
  - 2018 15/100
  - 2019 TBD
  - 2020 TBD
  - 2021- actual mean or median

**IMPACT:** This means fewer dollars will be available for redistribution from poor performers to high performers.
MIPS Changes in BBA 2018

Before BBA 2018
- Exceptional performance not time limited

Under BBA 2018
- Exceptional performance category ends in 2024 payment year
MIPS Changes in BBA 2018

Before BBA 2018
- Fee schedule update
  - 2016 0.5%
  - 2017 0.5%
  - 2018 0.5%
  - 2019 0.5%

Under BBA 2018
- Fee schedule update
  - 2016 0.5%
  - 2017 0.5%
  - 2018 0.5%
  - 2019 0.25%
# MACRA Timeline

<table>
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<th>Pre MACRA (PQRS, MU, VBM)</th>
<th>MACRA</th>
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<td><strong>Qualified Participation Advanced APM</strong></td>
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<td>Lump Sum Bonus (total allowed charges)</td>
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QPP Basics

Eligible Clinicians earn performance based adjustments to fee for service

OR

Qualifying participants earn bonus based on allowed charges
# MIPS Eligible Clinicians

## Inclusions 2018
- Physician
- Physician Assistant
- Nurse practitioner
- Clinical Nurse Specialist

## Inclusions 2019
- Physical therapist
- Occupational therapist
- Qualified speech-language pathologist
- Qualified audiologist
- Clinical psychologist
- Registered dietitian or nutrition professionals

## Exclusions
- 1st year Medicare QP in Advanced APM
- Partial QP (election)

Do not exceed low volume threshold
## 2019 Change to Low Volume Threshold

### Table

<table>
<thead>
<tr>
<th>Beneficiaries</th>
<th>Dollars</th>
<th>Covered Professional Services</th>
<th>Eligible for Opt-in</th>
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</thead>
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<tr>
<td>≤ 200</td>
<td>≤ 90K</td>
<td>≤ 200</td>
<td>Excluded not eligible to Opt-in</td>
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<tr>
<td>≤ 200</td>
<td>≤ 90K</td>
<td>&gt; 200</td>
<td>Eligible to Opt-in, Voluntarily Report, or Not Participate</td>
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<tr>
<td>≤ 200</td>
<td>&gt; 90K</td>
<td>≤ 200</td>
<td>Eligible to Opt-in, Voluntarily Report, or Not Participate</td>
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<td>&gt; 200</td>
<td>≤ 90K</td>
<td>&gt; 200</td>
<td>Eligible to Opt-in, Voluntarily Report, or Not Participate</td>
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<tr>
<td>&gt; 200</td>
<td>&gt; 90K</td>
<td>&gt; 200</td>
<td>Not eligible to Opt-in, Required to Participate</td>
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</tbody>
</table>

### 2019: Eligibility to opt in to MIPS defined.
This option, if exercised, cannot be revoked for the performance year.

### QPP Participation Status

Enter your 10-digit [National Provider Identifier (NPI)](https://qpp.cms.gov/participation-lookup) or number to view your QPP participation status by performance year (PY).

QPP Participation Status includes APM Participation as well as MIPS Participation.

## MIPS 2019 Performance Category Weights

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
<td>50%</td>
<td>45%</td>
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<tr>
<td>Cost</td>
<td>0%</td>
<td>10%</td>
<td>15%</td>
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<tr>
<td>Improvement Activities</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>25%</td>
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</table>
# MIPS 2019 Performance Category Periods

<table>
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<tr>
<th>Performance Category</th>
<th>Performance Category Period</th>
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<tr>
<td>Quality</td>
<td>90 Days</td>
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<tr>
<td>Cost</td>
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<tr>
<td>Improvement Activities</td>
<td>90 Days</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>90 Days</td>
</tr>
</tbody>
</table>
Quality Category

• 6 best performing measures
  – 1 outcome measure, even if reporting from specialty set
• 60 achievement points
• Scoring based on benchmarks
• Bonus Points: High-Priority Measures (after first required measure)
  – 2 points for outcome, patient experience
  – 1 point for other high priority measures which need to meet the data completeness and case minimum requirements along with having a performance rate of greater than 0.
  – Capped bonus points at 10% of the denominator of total Quality performance category
• Bonus Points: End-to-End Electronic Reporting:
  – 1 point for each measure submitted using end-to-end electronic reporting.
  – Capped at 10% of the denominator of total Quality performance category points.
• Full year reporting
• 60% data completeness threshold
Quality Category
Significant 2019 Changes

• Weight of category 45%
• Small groups (<=15) can submit Part B Claims measures whether reporting individually or as a group.
• In Year 3, individual ECs, groups and virtual groups can submit measures via multiple collection types (MIPS CQM, eCQM, QCDR measures, CMS Web Interface measures for large practices, and Medicare Part B claims measures for small practices).
  – If the same measure is submitted via multiple collection types, the one with the greatest number of measure achievement points will be selected for scoring
### Quality Category
New Terms

#### TABLE 33: Data Submission Types for MIPS Eligible Clinicians Reporting as Groups

<table>
<thead>
<tr>
<th>Performance Category/Submission Combinations Accepted</th>
<th>Submission Types</th>
<th>Submitter Type</th>
<th>Collection Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Direct Log in and upload CMS Web Interface (groups of 25 or more eligible clinicians) Medicare Part B claims (small practices)¹</td>
<td>Group or Third Party Intermediary</td>
<td>eCQMs MIPS CQMs QCDR measures CMS Web Interface measures Medicare Part B claims measures (small practices) CMS approved survey vendor measure Administrative claims measures</td>
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<tr>
<td>Cost</td>
<td>No data submission required¹²</td>
<td>Group</td>
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<tr>
<td>Promoting Interoperability</td>
<td>Direct Log in and upload Log in and attest</td>
<td>Group or Third Party Intermediary</td>
<td>-</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Direct Log in and upload Log in and attest</td>
<td>Group or Third Party Intermediary</td>
<td>-</td>
</tr>
</tbody>
</table>

¹ Third party intermediary does not apply to Medicare Part B claims submission type.

² Requires no separate data submission to CMS; measures are calculated based on data available from MIPS eligible clinicians’ billings on Medicare claims. **NOTE**: As used in this rule, the term “Medicare Part B claims” differs from “administrative claims” in that “Medicare Part B claims” require MIPS eligible clinicians to append certain billing codes to denominator-eligible claims to indicate the required quality action or exclusion occurred.
Quality Category
Significant 2019 Changes

• Small Practice Bonus:
  – The small practice bonus will now be added to the Quality performance category, rather than in the MIPS final score calculation
  – 6 bonus points are added to the numerator of the Quality performance category for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure.
### MIPS Quality Measures 2018*

**2019 Measures and benchmarks have not been released at press time**

<table>
<thead>
<tr>
<th>MIPS Quality Measure Number</th>
<th>Measure Name</th>
<th>2017 Urology Specialty Set</th>
<th>2018 Urology Specialty Set</th>
<th>True Resonance with urologists</th>
<th>Claims</th>
<th>Register</th>
<th>EHR</th>
<th>Web Interface</th>
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<tr>
<td>Q023</td>
<td>Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Q047</td>
<td>Care Plan</td>
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<td>x</td>
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<td>Q048</td>
<td>Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Wc</td>
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<td>x</td>
<td>x</td>
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<td>Q050</td>
<td>Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older</td>
<td>x</td>
<td>x</td>
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<td>Q102</td>
<td>Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer</td>
<td>x</td>
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<td>Q104</td>
<td>Prostate Cancer: Adjuvant Hormonal Therapy for High Risk or Very High Risk Prostate Carcinoma</td>
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<td>Q119</td>
<td>Diabetes: Medical Attention for Nephropathy</td>
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<td>Q128</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
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<td>x</td>
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<td>Q130</td>
<td>Documentation of Current Medications in the Medical Record</td>
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<td>Q131</td>
<td>Pain Assessment and Follow-Up</td>
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<td>Q226</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
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<td>Q265</td>
<td>Biopsy Follow-Up</td>
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<td>Q317</td>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Document</td>
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<td>Q358</td>
<td>Patient-Centered Surgical Risk Assessment and Communication</td>
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<td>Q374</td>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
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<td>Q428</td>
<td>Pelvic Organ Prolapse: Preoperative Assessment of Occult Stress Urinary Incontinence:</td>
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<td>Q429</td>
<td>Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy:</td>
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<td>Q431</td>
<td>Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling</td>
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<td>Q432</td>
<td>Proportion of Patients Sustaining aBladder Injury at the Time of any Pelvic Organ Prolapse Repair:</td>
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<td>Proportion of Patients Sustaining aBowel Injury at the time of any Pelvic Organ Prolapse Repair:</td>
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<td>Q434</td>
<td>Proportion of Patients Sustaining aUreter Injury at the Time of any Pelvic Organ Prolapse Repair:</td>
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<td>Q462</td>
<td>Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy</td>
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<td>x</td>
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*Very few Outcome Measures available to Urology*
<table>
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<tr>
<th>Measure_Name</th>
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<th>Submission Method</th>
<th>Measure Type</th>
<th>Benchmark</th>
<th>Average</th>
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<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control</td>
<td>1</td>
<td>Claims</td>
<td>Intermediate Outcome</td>
<td>Y</td>
<td>22</td>
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<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control</td>
<td>1</td>
<td>Registry/QCDR</td>
<td>Intermediate Outcome</td>
<td>Y</td>
<td>49.4</td>
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<tr>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control</td>
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<td>Registry/QCDR</td>
<td>Intermediate Outcome</td>
<td>Y</td>
<td>34.8</td>
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<td>Adult Kidney Disease: Blood Pressure Management</td>
<td>122</td>
<td>Registry/QCDR</td>
<td>Intermediate Outcome</td>
<td>Y</td>
<td>84.7</td>
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<td>Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR</td>
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<td>Registry/QCDR</td>
<td>Outcome</td>
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<td>Documentation of a Plan of Care</td>
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<td>Coronary Artery Bypass Graft (CABG): Prolonged Intubation</td>
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<td>Registry/QCDR</td>
<td>Outcome</td>
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<td>Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration</td>
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<td>Registry/QCDR</td>
<td>Outcome</td>
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<td>Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery</td>
<td>191</td>
<td>EHR</td>
<td>Outcome</td>
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<td>88.1</td>
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<tr>
<td>Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery</td>
<td>191</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
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<td>85.6</td>
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<td>Controlling High Blood Pressure</td>
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<td>Claims</td>
<td>Intermediate Outcome</td>
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<td>71.4</td>
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<td>Controlling High Blood Pressure</td>
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<td>EHR</td>
<td>Intermediate Outcome</td>
<td>Y</td>
<td>61.7</td>
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<tr>
<td>Controlling High Blood Pressure</td>
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<td>Registry/QCDR</td>
<td>Intermediate Outcome</td>
<td>Y</td>
<td>68.1</td>
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<td>Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery</td>
<td>303</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>Y</td>
<td>58.8</td>
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<td>Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery</td>
<td>304</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
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<td>57.3</td>
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<td>Pain Brought Under Control Within 48 Hours</td>
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<td>Registry/QCDR</td>
<td>Outcome</td>
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<td>90.1</td>
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<td>Screening Colonoscopy Adenoma Detection Rate</td>
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<td>Registry/QCDR</td>
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<td>51.1</td>
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<td>Hypertension: Improvement in Blood Pressure</td>
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<td>EHR</td>
<td>Intermediate Outcome</td>
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<td>33.1</td>
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<td>Adherence to Antipsychotic Medications For Individuals with Schizophrenia</td>
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<td>Registry/QCDR</td>
<td>Intermediate Outcome</td>
<td>Y</td>
<td>81.2</td>
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<td>Cataract Surgery: Difference Between Planned and Final Refraction</td>
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<td>Registry/QCDR</td>
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<td>61.9</td>
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<td>Anesthesia Smoking Abstinence</td>
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<td>Registry/QCDR</td>
<td>Intermediate Outcome</td>
<td>Y</td>
<td>64.2</td>
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<td>Psoriasis: Clinical Response to Oral Systemic or Biologic Medications</td>
<td>410</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>Y</td>
<td>69.7</td>
</tr>
<tr>
<td>Screening Mammography Cancer Detection Rate</td>
<td>ACRAD3</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>Y</td>
<td>5.1</td>
</tr>
<tr>
<td>Screening Mammography Abnormal Interpretation Rate (Recall Rate)</td>
<td>ACRAD5</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>Y</td>
<td>9.8</td>
</tr>
<tr>
<td>Screening Mammography Positive Predictive Value 2 (PPV2 - BiopsyRecommended)</td>
<td>ACRAD6</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>Y</td>
<td>27.7</td>
</tr>
<tr>
<td>Three Day All Cause Return ED Visit Rate ?All</td>
<td>ECPR11</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>Y</td>
<td>5</td>
</tr>
<tr>
<td>30 day Readmission for Heart Failure</td>
<td>PINC2</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>Y</td>
<td>14.6</td>
</tr>
<tr>
<td>30 day Readmission for Pneumonia</td>
<td>PINC3</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>Y</td>
<td>13.8</td>
</tr>
<tr>
<td>Prolonged Length of Stay following CABG</td>
<td>STS1</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>Y</td>
<td>5.3</td>
</tr>
<tr>
<td>Prolonged Length of Stay following CABG and Valve Surgery</td>
<td>STS3</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>Y</td>
<td>11.1</td>
</tr>
<tr>
<td>Prolonged Length of Stay following Valve Surgery</td>
<td>STS5</td>
<td>Registry/QCDR</td>
<td>Outcome</td>
<td>Y</td>
<td>5.5</td>
</tr>
</tbody>
</table>
Quality Category Scoring

How is my Quality performance category percent score calculated?

\[
\text{Quality Performance Category Percent Score} = \frac{\text{Total Measure Achievement Points} + \text{Measure Bonus Points}}{\text{Total Available Measure Achievement Points}} + \text{Improvement Percent Score}
\]

*Total Available Measure Achievement Points = the number of required measures \times 10*
<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Type</th>
<th>Measure Method</th>
<th>Measure ID</th>
<th>Submission Method</th>
<th>Benchmark</th>
<th>Topped</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perioperative Care: Venous Thromboembolism (VTE)</td>
<td>Process</td>
<td>Claims</td>
<td>23</td>
<td></td>
<td>Y</td>
<td>97.3</td>
</tr>
<tr>
<td>Perioperative Care: Venous Thromboembolism (VTE)</td>
<td>Process</td>
<td>Registry/QCDI</td>
<td>23</td>
<td></td>
<td>Y</td>
<td>94.8</td>
</tr>
<tr>
<td>Care Plan</td>
<td>Process</td>
<td>Claims</td>
<td>47</td>
<td></td>
<td>Y</td>
<td>67.1</td>
</tr>
<tr>
<td>Care Plan</td>
<td>Process</td>
<td>Registry/QCDI</td>
<td>47</td>
<td></td>
<td>Y</td>
<td>73.2</td>
</tr>
<tr>
<td>Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older</td>
<td>Process</td>
<td>Claims</td>
<td>48</td>
<td></td>
<td>Y</td>
<td>68.9</td>
</tr>
<tr>
<td>Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older</td>
<td>Process</td>
<td>Registry/QCDI</td>
<td>48</td>
<td></td>
<td>Y</td>
<td>70.2</td>
</tr>
<tr>
<td>Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older</td>
<td>Process</td>
<td>Claims</td>
<td>50</td>
<td></td>
<td>Y</td>
<td>87.2</td>
</tr>
<tr>
<td>Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older</td>
<td>Process</td>
<td>Registry/QCDI</td>
<td>50</td>
<td></td>
<td>Y</td>
<td>90.5</td>
</tr>
<tr>
<td>Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients</td>
<td>Process</td>
<td>EHR</td>
<td>102</td>
<td></td>
<td>N</td>
<td>--</td>
</tr>
<tr>
<td>Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients</td>
<td>Process</td>
<td>Registry/QCDI</td>
<td>102</td>
<td></td>
<td>Y</td>
<td>98.3</td>
</tr>
<tr>
<td>Prostate Cancer: Adjuvant Hormonal Therapy for High Risk or Very High Risk Prostate Cancer</td>
<td>Process</td>
<td>Registry/QCDI</td>
<td>104</td>
<td></td>
<td>Y</td>
<td>93.7</td>
</tr>
<tr>
<td>Diabetes: Medical Attention for Nephropathy</td>
<td>Process</td>
<td>EHR</td>
<td>119</td>
<td></td>
<td>Y</td>
<td>76.7</td>
</tr>
<tr>
<td>Diabetes: Medical Attention for Nephropathy</td>
<td>Process</td>
<td>Registry/QCDI</td>
<td>119</td>
<td></td>
<td>Y</td>
<td>81.4</td>
</tr>
<tr>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>Process</td>
<td>Claims</td>
<td>128</td>
<td></td>
<td>Y</td>
<td>72.6</td>
</tr>
<tr>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>Process</td>
<td>EHR</td>
<td>128</td>
<td></td>
<td>Y</td>
<td>45.5</td>
</tr>
<tr>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>Process</td>
<td>Registry/QCDI</td>
<td>128</td>
<td></td>
<td>Y</td>
<td>67.3</td>
</tr>
</tbody>
</table>
Quality Category Improvement Scoring

In the transition year (2017), the same MIPS eligible clinician earned 25 measure achievement points and 2 measure bonus points for reporting an additional outcome measure.

<table>
<thead>
<tr>
<th>Year</th>
<th>Quality performance category achievement percent score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>42%&lt;br&gt;25 achievement points + 60 possible points&lt;br&gt;Excludes the 2 bonus points</td>
</tr>
<tr>
<td>2018</td>
<td>55%&lt;br&gt;33 achievement points + 60 possible points&lt;br&gt;Excludes the 6 bonus points</td>
</tr>
</tbody>
</table>

The increase in Quality performance category achievement percent score from prior performance period to current performance period:

- 2017: 42%
- 2018: 55%
- Improvement percent score: 3.1%

The Improvement percent score:

\[(13\% + 42\%) \times 10\%\]
Quality Category
Take Home Messages

- Performance in this category is still the major determinant of success in MIPS (45%)
- Outcome measures are difficult to find for urology (only 3 in 2018 specialty set)
- Improvement scoring in this category is unlikely to make a huge impact
- Small practices should take advantage of 6 bonus points (2019)
MIPS Cost Category

- Two measures
  - Total Per Capita Costs
    - Part A,B adjusted costs for attributed beneficiaries
    - Attribution based on 2 step rules for (E&M services)
    - Case minimum of 20
  - Medicare Spending Per Beneficiary
    - Part A,B costs for episode around inpatient stay for attributed beneficiaries
    - Attribution based the most part B services ($) during trigger episode
    - Case minimum of 35
- CMS calculates from claims (no data submission requirement)
- Decile scoring method
- 20 achievement points
- Single national Benchmarks are based on current year
Cost Category
Significant 2019 Changes

• Weight of category: 15%
• Adding 8 new episode based measures
  – Case minimum
    • 10 for procedural episodes
    • 20 for acute inpatient medical condition episodes
  – None of these episodes affect urology
  – This is the framework going forward (11 episodes under development)
  – Likely to see kidney stone episode measure (procedural) in 2020
**TABLE 36: Episode-Based Measures Proposed for the 2019 MIPS Performance Period and Future Performance Periods**

<table>
<thead>
<tr>
<th>Measure Topic</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Outpatient Percutaneous Coronary Intervention (PCI)</td>
<td>Procedural</td>
</tr>
<tr>
<td>Knee Arthroplasty</td>
<td>Procedural</td>
</tr>
<tr>
<td>Revascularization for Lower Extremity Chronic Critical Limb Ischemia</td>
<td>Procedural</td>
</tr>
<tr>
<td>Routine Cataract Removal with Intraocular Lens (IOL) Implantation</td>
<td>Procedural</td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>Procedural</td>
</tr>
<tr>
<td>Intracranial Hemorrhage or Cerebral Infarction</td>
<td>Acute inpatient medical condition</td>
</tr>
<tr>
<td>Simple Pneumonia with Hospitalization</td>
<td>Acute inpatient medical condition</td>
</tr>
<tr>
<td>ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)</td>
<td>Acute inpatient medical condition</td>
</tr>
</tbody>
</table>
Cost Category
Take Home Messages

• No reporting requirement
• Little detail on performance available from CMS (2017)
• Urologists likely to see episode based measure for kidney stone in 2020
  – Case minimum 10
  – Trigger codes: ESWL, Ureteroscopy
  – Episode window: x days before, 90 days after
  – Field testing indicates wide variations in cost

• Basic levers for controlling costs:
  – Keep people out of ER
  – Minimize costly readmissions, retreatments
  – Render care at less costly facilities (ASC, not HOPD)
MIPS Improvement Activities

• 15% weight
• 40 achievement points
• 90 day reporting
• May report by attestation (or other methods)
• 1 EC has to perform the activity for the entire TIN to get credit
• Credit for HPSA (75% of NPIs have to be in HPSA)
• 113 Activities to choose from
### MIPS Improvement Activities Category

#### Examples

<table>
<thead>
<tr>
<th>Expanded Practice Access</th>
<th>Population Management</th>
<th>Care Coordination</th>
<th>Beneficiary Engagement</th>
<th>Patient Safety Practice Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Same Day appts for urgent needs (High)</td>
<td>• Participation in systematic anticoagulation program (High)</td>
<td>• Participate in CHS Transforming Clinical Practice Initiative (High)</td>
<td>• Access to patient portal (Medium)</td>
<td>• Consultation of RX Drug Monitoring Program prior to issuance of controlled substances (High)</td>
</tr>
<tr>
<td>• After Hours clinician advice (High)</td>
<td>• Participation in qualified clinical data registry (High)</td>
<td>• Timely communication of test results (Medium)</td>
<td>• Establishing care plans for complex patients (Medium)</td>
<td>• Administration of AHRQ Survey of Patient Safety Culture and submission (Medium)</td>
</tr>
<tr>
<td>• Telehealth services, participate in remote specialty consults (Medium)</td>
<td>• Monitoring health conditions and providing timely intervention (Medium)</td>
<td>• Monitoring health conditions and providing timely intervention (Medium)</td>
<td>• Participation in QCDR (Medium)</td>
<td>• Use of surgical checklists (Medium)</td>
</tr>
</tbody>
</table>

Table 8 - page 714

12301 Grant Street, Thornton, CO 80241 | Phone: (800) 972-9298 | Fax: (303) 534-0577
www.prsnetwork.com
Improvement Activities Category
Significant 2019 Changes

• Eliminating the bonus (PI Category) for completing certain improvement activities using CEHRT

• Adding 6 new Activities

• Modifying 5 existing Activities

• Removing 1 existing Activity
Improvement Activities Category

New Activities

- Comprehensive Eye Exams
- Financial Navigation Program: MIPS eligible clinicians must attest that their practice provides financial counseling to patients or their caregiver about costs of care and an exploration of different payment options.
- Completion of Collaborative Care Management Training Program (Psych)
- Relationship-Centered Communication (Primary Care)
- Patient Medication Risk Education (Opioids)
- Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support

NEW
Improvement Activities Category

Changed Activities (Minor)

- Care transition documentation practice improvements
- Participation in Population Health Research (Removed)
- Chronic Care and Preventative Care Management for Empaneled Patients
- Participation in MOC Part IV
- Use of Patient Safety Tools
- Implementation of analytic capabilities to manage total cost of care for practice population
Improvement Activities Category
Take Home Messages

• This is an easy category to achieve maximum points for urology
• No more bonus points for using CEHRT
MIPS Promoting Interoperability Category

• 25% weight
  – Can be reweighted to 0 for
    • Nurse practitioner, physician assistant, clinical nurse specialist, or certified registered nurse anesthetist.
    • Significant hardship
    • Extreme and uncontrollable circumstances

• 100 achievement points
• 90 day reporting
• New name (MU, ACI) reflects emphasis on interoperability
PI Category

Significant 2019 Changes

• Eligible clinicians must use 2015 Edition CEHRT (no more bonus)

• Completely new scoring methodology
PI Category
2019 Scoring Methodology

• Eliminating base, performance, and bonus scores
• Security Risk Analysis measure as a required measure without points
• Performance-based scoring at the individual measure-level. Each measure will be scored based on the MIPS eligible clinician’s performance for that measure based on the submission of a numerator or denominator, or a “yes or no” submission, where applicable
# PI Category
## 2019 Scoring Methodology

### TABLE 41: Scoring Methodology for the MIPS Performance Period in 2019

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measures</th>
<th>Maximum Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>e-Prescribing</strong></td>
<td>e-Prescribing**</td>
<td>10 points</td>
</tr>
<tr>
<td><strong>Bonus:</strong> Query of Prescription Drug Monitoring Program (PDMP)</td>
<td></td>
<td>5 point bonus</td>
</tr>
<tr>
<td><strong>Bonus:</strong> Verify Opioid Treatment Agreement</td>
<td></td>
<td>5 point bonus</td>
</tr>
<tr>
<td><strong>Health Information Exchange</strong></td>
<td>Support Electronic Referral Loops by Sending Health Information**</td>
<td>20 points</td>
</tr>
<tr>
<td></td>
<td>Support Electronic Referral Loops by Receiving and Incorporating Health Information**</td>
<td>20 points</td>
</tr>
<tr>
<td><strong>Provider to Patient Exchange</strong></td>
<td>Provide Patients Electronic Access to Their Health Information</td>
<td>40 points</td>
</tr>
<tr>
<td><strong>Public Health and Clinical Data Exchange</strong></td>
<td>Report to two different public health agencies or clinical data registries for any of the following: Immunization Registry Reporting**</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>Electronic Case Reporting**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Public Health Registry Reporting**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Data Registry Reporting**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Syndromic Surveillance Reporting**</td>
<td></td>
</tr>
</tbody>
</table>

**Exclusion available.**
Query of PDMP
5 Bonus points

- **Denominator**: Number of Schedule II opioids electronically prescribed using CEHRT by the MIPS eligible clinician during the performance period.

- **Numerator**: The number of Schedule II opioid prescriptions in the denominator for which data from CEHRT is used to conduct a query of a PDMP for prescription drug history except where prohibited and in accordance with applicable law. A numerator of at least one is required to fulfill this measure.
Support Electronic Referral Loops by Sending Health Information

• Name change from “Send a Summary of Care”
• Loosened requirements on type of C-CDA document meets this measure
• DENOMINATOR: The number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring clinician.
• NUMERATOR: The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.
Support Electronic Referral Loops by Receiving and Incorporating Health Information

- Replaced Request/Accept Summary of Care and Clinical Information Reconciliation measures
- **Denominator:** Number of electronic summary of care records received using CEHRT for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, and for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient.
- **Numerator:** The number of electronic summary of care records in the denominator for which clinical information reconciliation is completed using CEHRT for the following three clinical information sets:
  - Medication – Review of the patient’s medication, including the name, dosage, frequency, and route of each medication
  - Medication allergy – Review of the patient’s known medication allergies
- **Exclusions:**
  - Any MIPS eligible clinician who is unable to implement the measure for a MIPS performance period in 2019 would be excluded from this measure
  - Any MIPS eligible clinician who receives fewer than 100 transitions of care or referrals or has fewer than 100 encounters with patients never before encountered during the performance period would be excluded from this measure.
Provide Patients Electronic Access to Their Health Information

- Renamed from Provide Patients Access
- The MIPS eligible clinician provides patients (or patient-authorized representative) with timely electronic access to their health information (i.e. portal)
PI Measures Removed

• Patient-Generated Health Data
• Patient-Specific Education
• Secure Messaging Measure
• View, Download or Transmit
PI Category

Take Home Messages

• Performance based scoring means it will be nearly impossible to score 100 achievement points
• Must upgrade to 2015 CEHRT
• Practices need to implement EPCS
• Interoperability is the future, and need to master portal registration, sending and receiving summary of care
MIPS Bonus Points
Complex Patient Bonus

Individuals

\[
\text{[sum of all risk scores for the unique beneficiaries you treated between 9/1/17 and 8/31/18]} \quad + \quad \left( \frac{\text{[unique patients you treated who were dually eligible for Medicare and full- and partial-benefit Medicaid]}}{\text{[unique Medicare beneficiaries you treated]}} \right) \times 5 = \text{Your Complex Patient Bonus}
\]
MIPS COMPOSITE SCORE

Final Score

Quality
- Quality performance category percent score x Quality performance category weight

Cost
- Cost performance category percent score x Cost performance category weight

Improvement Activities
- Improvement Activities performance category score x Improvement Activities performance category weight

Promoting Interoperability
- Promoting Interoperability performance category score x actual Promoting Interoperability performance category weight

Bonus Points

\[ \text{Final Score} = \text{Quality} + \text{Cost} + \text{Improvement Activities} + \text{Promoting Interoperability} \times 100 \]
MIPS Payment Adjustments

1. Budget neutral payment adjustment
   – Determined by relative performance compared to threshold
   – Scaled up or down within statutory limits

2. Exceptional performance payment adjustment
   – Determined by being above exceptional threshold
   – Pro rata participation in $500 million pool
## MIPS Composite Score 2019

### High Level Changes

<table>
<thead>
<tr>
<th>Item</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final Score Threshold (pts)</td>
<td>3</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Exceptional Threshold (pts)</td>
<td>70</td>
<td>70</td>
<td>75</td>
</tr>
<tr>
<td>Maximum Adjustment (+/-%)</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Actual Scaled maximum adjustment (+/- %)</td>
<td>1.9</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
MIPS Adjustment PY 2019

Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Final Performance Threshold and Additional Performance Threshold for the 2019 MIPS Payment Year.
MIPS Adjustment PY 2020
Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Final Performance Threshold and Additional Performance Threshold for the 2020 MIPS Payment Year
MIPS Adjustment PY 2021

FIGURE 3: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Performance Threshold and Additional Performance Threshold for the 2021 MIPS Payment Year

- Performance Threshold = 30
- Adjustment Factor
- Adjustment Factor and Additional Adjustment Factor
- Final Score
- Adjustment Factors
- MIPS Adjustment PY 2021
## MIPS Payment Adjustments Methodology

<table>
<thead>
<tr>
<th>HCPCS Service</th>
<th>Charge</th>
<th>MPFS Price</th>
<th>MIPS Adjustment (-4%)</th>
<th>Allowed charge</th>
<th>Patient responsibility</th>
<th>Subtotal</th>
<th>Sequester</th>
<th>Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>xxxxx</td>
<td>$ 150.00</td>
<td>$ 100.00</td>
<td>$ (4.00)</td>
<td>$ 96.00</td>
<td>$ 19.20</td>
<td>$ 76.80</td>
<td>$ (1.54)</td>
<td>$ 75.26</td>
</tr>
<tr>
<td>yyyyy</td>
<td>$ 500.00</td>
<td>$ 190.00</td>
<td>$ (7.60)</td>
<td>$ 182.40</td>
<td>$ 36.48</td>
<td>$ 145.92 $ (2.92)</td>
<td>$ 143.00</td>
<td></td>
</tr>
</tbody>
</table>

- MIPS Adjustment is made on the full MPFS Price at line item level
- Patient responsibility is based on allowed charge (after MIPS adjustment)
- Sequester is applied only to 80% of allowed charge
### MIPS Impact on Average Urologist

What is 4% of Medicare Allowed Charges for a Typical Urologist?

<table>
<thead>
<tr>
<th></th>
<th>All NPI</th>
<th>All Urology</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPIs</td>
<td>1,020,483</td>
<td>8,986</td>
</tr>
<tr>
<td>Avg Professional Services</td>
<td>$106,360.39</td>
<td>$230,182.07</td>
</tr>
<tr>
<td>4% Professional Services</td>
<td>$4,254.42</td>
<td>$9,207.28</td>
</tr>
</tbody>
</table>

Based on Medicare Supplier file 2015
# MIPS 2020 Impact by Specialty

<table>
<thead>
<tr>
<th>Provider Type, Specialty</th>
<th>Number of MIPS eligible clinicians</th>
<th>Paid Amount (mil) **</th>
<th>Percent eligible clinicians engaging with quality reporting</th>
<th>Percent eligible clinicians with Positive or Neutral Payment Adjustment</th>
<th>Percent Eligible Clinicians with Positive Adjustment with Exceptional Payment Adjustment</th>
<th>Percent Eligible Clinicians with Negative Payment Adjustment</th>
<th>Aggregate Impact Positive Adjustment (mil)**</th>
<th>Aggregate Impact Negative Payment Adjustment (mil)**</th>
<th>Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Podiatry</td>
<td>9,318</td>
<td>$1,059</td>
<td>86.6%</td>
<td>87.7%</td>
<td>51.8%</td>
<td>12.3%</td>
<td>8.1</td>
<td>-7.2</td>
<td>0.1%</td>
</tr>
<tr>
<td>Preventive Medicine</td>
<td>225</td>
<td>$10</td>
<td>96.4%</td>
<td>97.3%</td>
<td>81.3%</td>
<td>2.7%</td>
<td>0.1</td>
<td>0.0</td>
<td>0.9%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>11,325</td>
<td>$463</td>
<td>94.4%</td>
<td>94.7%</td>
<td>70.3%</td>
<td>5.3%</td>
<td>3.6</td>
<td>-3.6</td>
<td>0.0%</td>
</tr>
<tr>
<td>Pulmonary Disease</td>
<td>9,126</td>
<td>$1,068</td>
<td>95.7%</td>
<td>96.6%</td>
<td>76.2%</td>
<td>3.4%</td>
<td>12.4</td>
<td>-2.5</td>
<td>0.9%</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>3,240</td>
<td>$873</td>
<td>98.1%</td>
<td>98.1%</td>
<td>78.6%</td>
<td>1.9%</td>
<td>8.9</td>
<td>-1.0</td>
<td>0.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>3,550</td>
<td>$1,099</td>
<td>96.7%</td>
<td>97.5%</td>
<td>77.5%</td>
<td>2.5%</td>
<td>13.9</td>
<td>-1.2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Sports Medicine</td>
<td>808</td>
<td>$58</td>
<td>96.7%</td>
<td>97.0%</td>
<td>75.1%</td>
<td>3.0%</td>
<td>0.6</td>
<td>-0.1</td>
<td>0.9%</td>
</tr>
<tr>
<td>Surgical Oncology</td>
<td>747</td>
<td>$51</td>
<td>98.5%</td>
<td>98.7%</td>
<td>80.7%</td>
<td>1.3%</td>
<td>0.6</td>
<td>-0.1</td>
<td>1.1%</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>1,842</td>
<td>$204</td>
<td>98.5%</td>
<td>98.6%</td>
<td>80.8%</td>
<td>1.4%</td>
<td>2.7</td>
<td>-0.2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Other</td>
<td>297</td>
<td>$32</td>
<td>98.3%</td>
<td>99.3%</td>
<td>79.1%</td>
<td>0.7%</td>
<td>0.4</td>
<td>0.0</td>
<td>1.1%</td>
</tr>
<tr>
<td>Urology</td>
<td>8,964</td>
<td>$1,505</td>
<td>95.6%</td>
<td>96.7%</td>
<td>72.7%</td>
<td>3.3%</td>
<td>16.8</td>
<td>-2.0</td>
<td>1.0%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>2,846</td>
<td>$662</td>
<td>96.1%</td>
<td>96.7%</td>
<td>72.2%</td>
<td>3.3%</td>
<td>7.1</td>
<td>-1.6</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

Notes:
*Standard scoring model assumes that a minimum of 90 percent of clinicians within each practice size category would participate in quality data submission.

MIPS 2021 Payment Year Impact

TABLE 76: MIPS Estimated Payment Year 2020 Impact on Paid Amount by Specialty, Standard Participation Assumptions *

<table>
<thead>
<tr>
<th>Provider Type, Specialty</th>
<th>Number of MIPS eligible clinicians</th>
<th>Paid Amount (mil) **</th>
<th>Percent eligible clinicians engaging with quality reporting</th>
<th>Percent Eligible Clinicians with Positive or Neutral Payment Adjustment</th>
<th>Percent Eligible Clinicians with a Positive Adjustment with Exceptional Payment Adjustment</th>
<th>Percent Eligible Clinicians with Negative Payment Adjustment</th>
<th>Aggregate Impact Positive Adjustment (mil)**</th>
<th>Aggregate Impact Negative Payment Adjustment (mil)**</th>
<th>Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>604,006</td>
<td>$55,444</td>
<td>96.8%</td>
<td>97.1%</td>
<td>74.4%</td>
<td>2.9%</td>
<td>618.2</td>
<td>-118.2</td>
<td>0.9%</td>
</tr>
<tr>
<td>2021</td>
<td>797,990</td>
<td>$66,611</td>
<td>97.8%</td>
<td>91.2%</td>
<td>58.8%</td>
<td>8.8%</td>
<td>890.0</td>
<td>-390.0</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

2019 Performance Year
- More participants
- More $ in pool
- More ECs with negative adjustment
- More opportunity for high performers
# MIPS

## Group vs Individual Reporting Considerations**

<table>
<thead>
<tr>
<th>Operational Considerations</th>
<th>Cultural Considerations</th>
<th>Financial Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Subject matter expertise</td>
<td>• Accountability vs responsibility</td>
<td></td>
</tr>
<tr>
<td>• Monitoring provider performance</td>
<td>• Compliance vs quality improvement</td>
<td></td>
</tr>
<tr>
<td>• Reporting burden</td>
<td>• Commitment to participating in alternative payment models</td>
<td></td>
</tr>
<tr>
<td>• Revenue cycle management (verifying accurate payments)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** CMS will track clinicians at the individual and TIN level even if their TIN reports as a group, and will assign the higher of the scores
Virtual Groups

- 2 or more TINs consisting of <11 clinicians each
- Report Quality and Cost as a group; must meet requirements of group reporting in ACI and IA categories (including aggregating performance data)
- MIPS participation thresholds calculated at individual level, not virtual group level
- A virtual group with >15 eligible clinicians will not be considered a “small practice”
- Must elect prior to Jan 1 and cannot leave during the performance period
Alternative Payment Models
Definitions

- APM: alternative payment models that CMS operates including demonstration projects
- MIPS APM: MIPS eligible clinicians participants and hold their participants accountable for the cost and quality of care provided to Medicare beneficiaries
- Advanced APM: must meet three criteria
  - participants to use certified electronic health record technology (CEHRT)
  - Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS)
  - Either: 1) be a Medical Home Model expanded under CMS Innovation Center authority; or 2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses
Alternative Payment Models

2019 PY Estimates
- 165-220k QPs
- $600-800 M

• Advanced APM (11)
• MIPS APM (13)
• CMS APM (37)

Qualified Participants
Partial QP
Qualified Participants
## MACRA Alternative Payment Models

CMS Endorsed APMS in MACRA

<table>
<thead>
<tr>
<th>MIPS APMs</th>
<th>Advanced APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>- BPCI Advanced</td>
<td>- BPCI Advanced</td>
</tr>
<tr>
<td>- CEC LDO</td>
<td>- CEC LDO</td>
</tr>
<tr>
<td>- CEC non LDO track 1,2</td>
<td>- CEC non LDO track 2</td>
</tr>
<tr>
<td>- CPC+</td>
<td>- CPC+</td>
</tr>
<tr>
<td>- Independence at Home Demonstration (*2019)</td>
<td>- Independence at Home Demonstration</td>
</tr>
<tr>
<td>- Medicare ACO (all tracks)</td>
<td>- Medicare ACO (1+, 2,3)</td>
</tr>
<tr>
<td>- Medicare-MCD ACO (all tracks)</td>
<td>- Medicare-MCD ACO (2,3)</td>
</tr>
<tr>
<td>- NextGen ACO</td>
<td>- NextGen ACO</td>
</tr>
<tr>
<td>- OCM (all tracks)</td>
<td>- OCM (2)</td>
</tr>
<tr>
<td>- Vermont Medicare ACO</td>
<td>- Vermont Medicare ACO</td>
</tr>
</tbody>
</table>

Comprehensive ESRD Care large Dialysis Organization; Comprehensive Primary Care
## MIPS vs APMS

### MIPS APMs

If you participate in a MIPS APM and are eligible for MIPS:

- You’ll be scored using the APM Scoring Standard
- The 2018 MIPS APMs categories and weights are:
  - **50%** Quality
  - **20%** Improvement Activities
  - **30%** Promoting Interoperability

**The Cost performance category is not scored for MIPS APMs.**

- All APM participants get the same score
- Some APMs have their own quality measure sets
- Improvement activities can be credited

### Advanced APMs

If you are participating in an Advanced APM and are a QP:

You may earn a 5% incentive for achieving threshold levels of payments or patients through Advanced APMs:

- You receive 25% of your Medicare Part B payments through an Advanced APM; or
- See 20% of your Medicare patients through an Advanced APM

You are excluded from the MIPS reporting requirements and payment adjustment.

You’ll need to send in the quality data required by your Advanced APM. Your model’s website will tell you how to send in your Advanced APM’s quality data.

Partial QPs may choose to participate in MIPS. If a Partial QP reports on applicable measures and activities required under MIPS for a year, the Partial QP is eligible for a MIPS payment adjustment.
Physician-Focused Payment Model Technical Advisory Committee (PTAC)

- Created by MACRA
- Make comments and recommendations to the Secretary of the Department of Health and Human Services (the Secretary, HHS) on proposals for PFPMs submitted by individuals and stakeholder entities.
PTAC believes that increasing the utilization of active surveillance (AS) for low-risk prostate cancer patients, particularly among minority communities, should be a priority for HHS. However, PTAC was not convinced that providers should receive an “incentive” to deliver guideline-supported care that is in the best interests of their patients.
How to Maximize Performance/Reimbursement in QPP

• Determine your participation status
• Designate a MACRA/MIPS SME and keep current or hire an expert
  – Subscribe to updates [https://www.cms.gov/newsroom](https://www.cms.gov/newsroom)
• Monitor your Quality and PI scores.
• Focus improvement efforts
• For 2019, achieve a score of 75 points or greater
What is the Role of EHR Vendors in MIPS?

- 2015 CEHRT and updated CQM
  [https://chpl.healthit.gov/#/search](https://chpl.healthit.gov/#/search)

- EHR may determine what Quality measures available to you
  - Most specialty EHRs cannot report on all measures

- Most EHRs can produce reports on Quality and PI measures
  - Use them to focus improvement efforts

- EHR vendor may be “third party intermediary” for submission of measures
What is the Role of Registry (QCDR) Vendors?

- Registry may be “third party intermediary” for submission of measures
  - Quality
  - Improvement Activities
  - PI
- QCDR may have “urology specific measures”
  - Beware no benchmarks (3 points)
- Registry may be both
  - QCDR
  - Clinical Data Registry
# QCDR

## Table of Contents

Below is a list of the 2018 Qualified Clinical Data Registries for MIPS

Disclaimer: The Merit-based Incentive Payment System (MIPS) Final approved 2018 Qualified Clinical Data Registries (QCDRs) List is a list of all entities that are authorized by the Centers for Medicare & Medicaid Services (CMS) to submit Quality Measures (MIPS quality measures and/or QCDR measures), Advancing Care Information Measures, and/or Improvement Activities on behalf of MIPS-eligible clinicians, groups, and/or virtual groups for purposes of MIPS for the 2018 performance year. CMS has not otherwise evaluated the capabilities, quality, or any other features of any specific entity or its products referenced on the MIPS Final approved 2018 QCDR list. Reference to any specific entity, commercial product, process, or service (collectively, “specific entity or its products”) on the MIPS Final approved 2018 QCDR list does not constitute any endorsement or recommendation of the specific entity or its products by CMS or the United States Government. Such reference does not imply that a specific entity or its products meets any other federal health care program requirements applicable to the entity or its products or to MIPS-eligible clinicians, groups, and/or virtual groups on whose behalf the entity submits data to CMS. Prior to selecting or using any specific entity or its products, MIPS-eligible clinicians, groups, and/or virtual groups should perform their own due diligence on the entity and its products, including contacting the entity directly to learn more about its products.

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Quality</th>
<th>Improvement Activities</th>
<th>Advancing Care Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Urological Association Quality (AQUA) Registry</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Anesthesia Quality Institute (AQI) National Anesthesia Clinical Outcomes Registry (NACOR)</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia Quality Registry (AQR QCDR)</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>AOA MORE - Measures and Outcomes Registry for Eyecare</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APMA Registry</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>AQUIRE Quality Improvement Registry</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Arcadia Analytics</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Measures Supported</td>
<td>eCQMs Supported</td>
<td>QCQR Measures Supported</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------</td>
<td>------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| Quality IDs: 023, 046, 047, 048, 050, 102, 104, 110, 113, 119, 128, 130, 131, 226, 236, 265, 317, 357, 358, 431, 462 | Quality IDs: 102, 110, 113, 119, 128, 130, 226, 236, 317, 462 | - Diagnosis of Type of Azoospermia and Diagnostic Testing for Obstructive Azoospermia  
- Genetic Testing of the Azoospermic Male  
- Appropriate Management of Obstructive Azoospermia  
- Non-Muscle Invasive Bladder Cancer: Repeat Transurethral Resection of Bladder Tumor (TURBT) for T1 disease  
- Non-Muscle Invasive Bladder Cancer: Initiation of BCG 3 months of diagnosis of high-grade T1 bladder cancer and/or CIS  
- Non-Muscle Invasive Bladder Cancer: Early surveillance cystoscopy within 4 months of initial diagnosis  
- Prostate Cancer: Confirmation Testing in low risk active surveillance eligible patients  
- Prostate Cancer: Follow-Up Testing for patients on active surveillance for at least 30 months  
- Prostate Cancer: Active Surveillance/Watchful Waiting for Low Risk Prostate Cancer Patients  
- Bone imaging and soft tissue imaging at the time of diagnosis of metastatic CPAC  
- Blood work for patients receiving abiraterone  
- Testosterone and PSA levels checked for CRPC patients  
- Use of Prednisone for CRPC patients on abiraterone  
- Prostate Cancer: Patient Report of Urinary function after treatment  
- Prostate Cancer: Patient Report of Sexual function after treatment  
- Benign Prostate Hyperplasia Care: Benign Prostate Hyperplasia  
- Benign Prostate Hyperplasia: IPSS improvement after diagnosis  
- Stones: Urinalysis documented 30 days before surgical stone procedures  
- Hospital admissions/complications within 30 days of TRUS Biopsy  
- Stones: Repeat Shock Wave Lithotripsy (SWL) within 6 months of treatment  
- Cryptorchidism: Inappropriate use of scrotal/groin ultrasound on boys  
- Stress Urinary Incontinence (SUI): Revision surgery within 12 months of incontinence procedure  
- Appropriate Testing for Vasectomy Patients  
- Hypogonadism: Testosterone and hematocrit within 6 months of starting testosterone replacement |
What is the Role of Consultants?

- Consultants may offer
  - Turnkey services vs coaching
  - Subcontract to QCDR
  - Periodic reporting, trending, and change management
  - Per Provider pricing
Key Takeaways

- QPP is live, complicated, compulsory for most specialists, still largely based on fee for service, and catalyzing the shift to “Value Based Reimbursement”.

- Key changes in 2019
  - More participants and higher bar for success
  - Cost assuming more weight without transparency.
  - Kidney stone episodes are imminent (2020). Model if possible.
  - Pressure to promote interoperability and exchange information

- MACRA is designed to encourage participation in Alternative payment models, but there are no APMs in urology and PTAC process is dysfunctional
Thank you

Bob Dowling MD

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817-264-6135
Medicare Update 2019
Multiple Procedure Discount for E/M

• Scrapped for Now
• To apply to all E/M codes with modifier -25
• 50% reduction of lowest paying code (mostly E/M codes) submitted on same date
• CMS Projected Savings 6.7 million RVUs a year (roughly $239 million dollars)
E and M Changes 2019

- History of Present Illness (HPI) can be documented by patient or staff and reviewed by provider.
- Review of Systems (ROS) and Past Family and Social History (PFSH) that have previously been documented in the chart can be reviewed and updated without re-documenting all elements and without reference to collection date.
- Physical Exam that has been documented in the medical record can be reviewed by the physician, for established patients.
2021

Major changes for E/M codes

- Paying a single rate for E/M office/outpatient visit levels 2, 3, and 4 with a minimum documentation requirement meeting a level 2 visit
- E/M office/outpatient levels 1 and 5 visits will continue to have unique payment levels
- New add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of specialized medical care (includes urology) for use with levels 2-4 only
- New “extended-visit” add-on code for use only with E/M office/outpatient level 2 through 4 visits
- Increased flexibility in how visit levels are documented, specifically a choice to use the current “level 2” framework (as discussed above), medical decision-making only, or time
- Elimination of the requirement for counseling or coordinating care to charge based on time.
# Conversion Factor 2019

<table>
<thead>
<tr>
<th>Conversion Factor in effect in CY 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$35.9996</td>
<td></td>
</tr>
<tr>
<td>Update Factor CY</td>
<td>0.25 percent (1.0025)</td>
</tr>
<tr>
<td>2017 RVU Budget Neutrality Adjustment</td>
<td>-0.12 percent (0.9988)</td>
</tr>
<tr>
<td>CY 2018 Proposed CF</td>
<td>$36.0391</td>
</tr>
</tbody>
</table>

RVU changes Urology Impact according to Medicare  3.0%
RVU Winners and Losers
<table>
<thead>
<tr>
<th>Code</th>
<th>MOD</th>
<th>Description</th>
<th>NFTot REVU</th>
<th>FTot RVU</th>
<th>Global</th>
<th>NF % Change</th>
</tr>
</thead>
<tbody>
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<td>52334</td>
<td>0</td>
<td>Create passage to kidney</td>
<td>5.3</td>
<td>5.3</td>
<td>000</td>
<td>-29%</td>
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<td>53850</td>
<td>0</td>
<td>Prostatic microwave thermotx</td>
<td>45.41</td>
<td>10.1</td>
<td>090</td>
<td>-24%</td>
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<td>53852</td>
<td>0</td>
<td>Prostatic rf thermotx</td>
<td>43.97</td>
<td>10.86</td>
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<td>1.61</td>
<td>XXX</td>
<td>-19%</td>
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<td>Electro-uroflowmetry first</td>
<td>0.17</td>
<td>0.17</td>
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<td>55873</td>
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<td>-13%</td>
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<tr>
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<td>Us compl joint r-t w/img</td>
<td>2.51</td>
<td>2.51</td>
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<td>-13%</td>
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<td>76942</td>
<td>TC</td>
<td>Echo guide for biopsy</td>
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<td>-10%</td>
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<td>52647</td>
<td>0</td>
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<td>52648</td>
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<tr>
<td>55874</td>
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<td>Tprnl plmt biodegradable matrl</td>
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<td>000</td>
<td>-6%</td>
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<tr>
<td>51701</td>
<td>0</td>
<td>Insert bladder catheter</td>
<td>1.27</td>
<td>0.73</td>
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<td>-6%</td>
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<tr>
<td>50606</td>
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<td>Endoluminal bx urtr rnl plvs</td>
<td>18.8</td>
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<td>ZZZ</td>
<td>-6%</td>
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<td>51784</td>
<td>TC</td>
<td>Anal/urinary muscle study</td>
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<td>76942</td>
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<td>XXX</td>
<td>-5%</td>
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<td>76802</td>
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<td>0.61</td>
<td>0.61</td>
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<td>Description</td>
<td>NFTot REVU</td>
<td>FTot RVU</td>
<td>Global</td>
<td>NF % Change</td>
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<td>----------</td>
<td>--------</td>
<td>-------------</td>
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<tr>
<td>51729</td>
<td>0</td>
<td>Cystometrogram w/vp&amp;up</td>
<td>10.21</td>
<td>10.21</td>
<td>000</td>
<td>5%</td>
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<tr>
<td>52214</td>
<td>0</td>
<td>Cystoscopy and treatment</td>
<td>20.00</td>
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<td>000</td>
<td>5%</td>
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<td>51726</td>
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<td>7.94</td>
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<td>5%</td>
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<tr>
<td>52224</td>
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<td>20.90</td>
<td>5.89</td>
<td>000</td>
<td>5%</td>
</tr>
<tr>
<td>50728</td>
<td>0</td>
<td>Revise ureter</td>
<td>21.23</td>
<td>21.23</td>
<td>090</td>
<td>5%</td>
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<tr>
<td>50434</td>
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<td>Convert nephrostomy catheter</td>
<td>24.66</td>
<td>5.60</td>
<td>000</td>
<td>5%</td>
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CPT Changes
• 50395 Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous
Change

• 74485  Dilation of ureter(s) or urethra, radiological supervision and interpretation
New

- 50436 Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed.

- 50437 Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed; including new access into the renal collecting system.
New

• 53854  Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy
Tele (?)
Three Types

- Telemedicine – Synchronous data with live video and audio

- TeleHealth (ATA) – asynchronous data and telephone interaction. No video required but could be used.

- TeleServices - Charges to the patient for services provided via telephone
Medicare Rules

- Telemedicine – video required. Patient must be in an approved facility.
- TeleHealth – Not allowed by Medicare with exceptions and workarounds and of course the new codes.
- TeleServices – Non-covered services – unencumbered billing.
- Note of patient approval and acceptance of services for a fee.
Medicare Codes

- G2012 Brief communication technology based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
Medicare Codes

• G2010 Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
CPT Code Changed

- 99446 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requiring physician or other qualified healthcare professional; 5-10 minutes of medical consultative discussion and review
CPT Code Changed

• 99447 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review
CPT Code Changed

- 99448 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review
CPT Code Changed

• 99449 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review
New CPT Codes

• 99451  Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
New CPT Codes

• 99452 Interprofessional telephone/Internet / electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes
New CPT Codes

- 99453 Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
New CPT Codes

- 99454 Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
New CPT Codes

• 99457 Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month
Break

Thank you to our exhibitors
Positioning the Practice for Profitability

Aligning Analytics, Opportunities, Tactical Leadership

Nov 30, 2018

Larry A. Kemp, FACHE
Overview

• Aligning Analytics
• Opportunities
• Tactical Leadership
Reality

The future keeps getting closer.
Trends - Urology Compensation 2018

Urologist Compensation by Geographic Area

- North Central: $466K
- Northeast: $438K
- Southwest: $435K
- South Central: $430K
- Great Lakes: $419K
- West: $415K
- Northwest: $398K
- Mid-Atlantic: $372K
- Southeast: $347K

*West includes Alaska and Hawaii
Healthcare Trends

- Reimbursement and payment challenges
- Endless regulatory compliance burdens
- Staffing skills and shortages
- Complexity and cost of new data systems
- Growing overall financial risk
- Declining numbers of urologists
- Increasing levels of underinsured patients and unpaid collections
Business of Medicine

- Skilled financial/operations management
- Critical thinking to define profitable opportunities
- Collaborative models and interdisciplinary teams to implement best practices
- Efficient infrastructure for quality care delivery
- Policies and culture that promote efficiencies, cohesiveness, sustainable profits
Aligning Practice Analytics

Successful Decisions

Target - Data Dive - Analytics - ROI - Decision
Analytics – Why this is Important New Service Lines

• Business of medicine is complex
• Actionable financial data to align assets, cost, demand, delivery, ROI Assessment
• Clear data, active intelligence = better decisions
• Communicate decisions and specify support
• Define cost/value of care delivery model
• Impact of value/risk-based contracts
• Improving profitable income stream
Analytics - Better Decisions

- Financial issues often require difficult trade-offs
- Shortage of time, ability to properly process data, underestimating impact of change processes...
- Does investment risk fit with practice’s abilities?
- Is now the best time to onboard a new service?
- Focus on relevant data or the most available data?
- Key stakeholder view points, consensus, decision, support, action plan, successful execution
- Forecast and an Explanation – there's a difference
Analytics - Reality

• How you make decisions is as important as what decisions are made
• Priorities can be clouded by routine and comfort zone
• Insight, financials, operations, critical thinking
• Practice data streams can be overwhelming
• Target actionable data with solutions
• Deliver data-based business decisions
• Good plans require successful implementation
Aligning Analytics - Review

• Practice system-by-system review and apply solutions at multiple levels
• Data aligned with goals and metrics
• Good data is a convincing argument
• Align assets, costs, services, demand, value...
• Plan, execution, monitor and improve...
• If you can measure key points, you can manage it
• Target what’s important, not what’s easiest
Opportunities
Defining Opportunities

• Leading a team forward is difficult, but important
• Big picture focus - 5,000 ft view
• Culture/Size - defines core strategy
• Small, medium, large groups - Basic goals, different implementation models
• One size does not fit all
• Decision followed by team implementation
• One win, then another - Keep moving forward
Capitalizing on Opportunities

• Show what you’re trying to achieve
• Asking others to leave their comfort zone
• Define why the opportunity drives value
• Supporting data, proforma, action plans
• Define goals, objections, metrics, accountability
• Clear time lines for moving forward
• Action plan + effective implementation = Success
• Stay on target, lead, coach, help, show the way
Positioning for Profitability

Effective

• New business models for improving performance.
• Clear communication.
• Defined strategies and team engagement to support priorities.
• Culture supports a needed change model.
• Accountability.

Not Effective

• Same models same results - little improvement.
• Poor communication.
• Limited effort to engage team to support priorities.
• Little actionable plans or team engagement/support.
• Weak culture, little effort to affect change.
• Little accountability.
Tactical Leadership
Aligning Team – Goals + Assets
Tactical Leadership

- Hallmark of better performing practices
- Focus on key issues impacting the practice
- Understands Team effort required
- Harnessing Team’s talents instills confidence
- Engage Team, promotes positive culture
- Integrates a disciplined Team
Tactical Leadership – cont.

• Define Practice “Road Map” for success
• Clear goals and objectives
• Encourage practice “key champions”
• Clear agenda, clear instructions, stay focused
• Keep it simple so all can understand goals
• Find workable models and solutions
• Stay the course
Tactical Leadership - Review

• Hard targets, hard work, solid commitment
• Motivate, promote trust, share success
• Consistent communications
• Define action plans and time lines, always be involved
• Attention to details, but focus is Bigger Picture
• Implement integrated action plans
• Flexible – Focus on solutions
• Understand Teams drive success
• Represent the Group – stable, reliable, steady...
Reality

• Payors, competitors and government will continue to implement their own cost savings solutions.

• Making healthcare more cost-effective means different things to different stakeholders.

• Higher fees for services, more patient cost aligned with less utilization appears to be the new mantra.
Questions

Physician practices have, in many ways, the ability to manage their future.
Break

Thank you to our exhibitors
Compensation Trends
Physicians/APPs and Practice Leaders

Las Vegas, Nov 30, 2018
Larry A. Kemp, FACHE
Overview

Healthcare Trends
Hospital Employed and Private Practice
Value Based Plans
Trends

• Healthcare is 20% of GDP
• Healthcare is big business - Expenditures
  1. Pharma. 2. Hospital care. 3. Physician services
• Bulk of consumers spending goes to paying for insurance coverage
• Most receive health insurance through employer
  - Large tax-free subsidy
  - Benefit is the U.S.’s single biggest tax break

Trends

• Rising demand for specialized urological care
• Declining numbers of urologists
• Declining incentives, payments, uncertainties
• Little upside and limited downstream relief
• Regulatory burdens and growing financial risk
• Rising concerns for practice operating losses
• Impact as markets continue with more hospital-system ownership of physician practices
Compensation 2018

How Much Do Urologists Earn?

Plastic Surgery $501K
Orthopedics $497K
Cardiology $423K
Gastroenterology $408K
Radiology $401K
Dermatology $392K
Anesthesiology $386K
Otolaryngology $383K
Urology $373K
Oncology $363K
Ophthalmology $357K
Critical Care $354K
Emergency Medicine $350K
Surgery, General $322K
Pulmonary Medicine $321K
Ob/Gyn $300K
Nephrology $294K
Pathology $286K
Psychiatry $273K
Allergy & Immunology $272K
Physical Medicine & Rehabilitation $269K
Rheumatology $257K
Neurology $244K
Infectious Diseases $231K
Internal Medicine $230K
Family Medicine $219K
Diabetes & Endocrinology $212K
Pediatrics $212K
Public Health & Preventive Medicine $199K
### Are Urologists Up or Down?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>+16%</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>+14%</td>
<td>Plastic Surgery</td>
</tr>
<tr>
<td>+13%</td>
<td>Physical Medicine &amp; Rehabilitation</td>
</tr>
<tr>
<td>+10%</td>
<td>Oncology</td>
</tr>
<tr>
<td>+9%</td>
<td>Critical Care, Rheumatology</td>
</tr>
<tr>
<td>+6%</td>
<td>Anesthesiology, Allergy &amp; Immunology</td>
</tr>
<tr>
<td>+5%</td>
<td>Nephrology, Ob/Gyn, Pediatrics, Family Medicine</td>
</tr>
<tr>
<td>+4%</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>+3%</td>
<td>Ophthalmology, Pulmonary Medicine, Emergency Medicine, Cardiology</td>
</tr>
<tr>
<td>+2%</td>
<td>Internal Medicine, Dermatology, Orthopedics</td>
</tr>
<tr>
<td>+1%</td>
<td>Infectious Diseases, Radiology</td>
</tr>
<tr>
<td>-2%</td>
<td>Neurology, Pathology</td>
</tr>
<tr>
<td>-4%</td>
<td>Diabetes &amp; Endocrinology, Otolaryngology</td>
</tr>
<tr>
<td>-7%</td>
<td>Urology</td>
</tr>
<tr>
<td>-9%</td>
<td>Surgery, General</td>
</tr>
</tbody>
</table>
Who Earns More: Employed or Self-employed Urologists?

- Self-employed: $410K
- Employed: $391K

Compensation - 2018
Urology Trends 2018

Urologist Participation in Various Payment Models

- Fee-for-service: 53%
- Direct primary care: 8%
- Insurance: 84%
- Accountable care organization (ACO): 24%
- Cash-only practice: 5%
- Concierge practice: 1%
Compensation

• Practices face many challenges with comp models
• Must be viewed as fair and equitable
• Hospital Employed – impact of contract renewal
• Private practice - Pressure on net income driven by slim operating margins & financial exposure
• Expect loud feedback if comp is declining or top end is at risk
• Compensation drives practice cohesion, culture and sustainability
Compensation Plans

• Critical to recruiting/retaining physicians
• Aligns financial incentives with group’s goals
• Complex legal environment/changing payment models make aligning fair plans and consensus challenging
• Best plans are data driven, evidence-based and clearly define the comp package
• Analyzing practice’s current situation
• What’s working and what needs changing?
Compensation – cont.

• New payment models - Value-based compensation
• Define incentives with aligning physician comp with practice goals and objectives
• Data based models perceived as fair/equitable
• Practice value metrics needed for successful strategic alignment – Moving from RVRU’s and FFS
• Keep it simple to reduce resistance to change
• Show current/new comp models side by side
Compensation - cont.

- Incorporate new payment models into comp plans
- Key issues for hospital system-employed physicians
- Comp plan development/implementation in a variety of settings – Learn what’s working
- New incentive plans based on quality versus quantity is adding new levels of financial risk
- Payers, employers, CMS - driving cost containment
- Begin planning now
2019 and Beyond

Healthcare’s dynamic environment represents a formidable challenge to successful compensation plans. There is no cookie cutter solution.
Healthcare Environment

- Higher costs for providers of care and services - physicians and hospitals
- Expect increasing cost pressures from payors and more cost sharing for users (patients).
- New business mantra for payors and hospitals - Trim spending but increase cost of services
- Financial impact on physician practices is real
New Models

• Value-based payments transitioning from FFS to accountable value-based models
• Growing recognition of cost/quality of care impact on payments
• Payer’s growing financial oversight
• Focus – Physician/patient engagement, quality improvement, reduced cost through care management models, overall care/treatment effectiveness
Questions

As reimbursements and margins get smaller, expect financial pressure on sustainable compensation plans.